JOURNAL OF THE HOUSE

First Regular Session, 103rd General Assembly

FOURTEENTH DAY, THURSDAY, JANUARY 30, 2025

The House met pursuant to adjournment.

Speaker Patterson in the Chair.

Prayer by Reverend Monsignor Robert A. Kurwicki, Chaplain.

For you were called to freedom, brethren; only do not use your freedom as an opportunity for the flesh, but through love be servants of one another. (Galatians 5:13)

Almighty and everlasting God, Creator of all, in our hearts we come before You in all reverence and humility, confessing our need to Your forgiving grace and our desire to Your directing guidance. Help us to lift our spirits to You in prayer and praise and give us grace to dedicate our lives anew to You and to our citizens this wintery morning.

During these dark winter days that test our attitude, may the awareness of Your presence give us steady faith and steadfast love enabling us to work for the good of all Missouri.

And the House says, "Amen!"

The Pledge of Allegiance to the flag was recited.

The Speaker appointed the following to act as an Honorary Page for the day, to serve without compensation: Jonathan Jeffrey Hoelscher.

The Journal of the thirteenth day was approved as corrected by the following vote:

AYES: 140

Allen	Amato	Anderson	Baker	Barnes
Billington	Black	Boykin	Boyko	Bromley
Brown 149	Brown 16	Burton	Bush	Busick
Butz	Byrnes	Casteel	Caton	Chappell
Christ	Christensen	Clemens	Coleman	Cook
Costlow	Crossley	Davidson	Davis	Dean
Deaton	Diehl	Dolan	Doll	Douglas
Durnell	Elliott	Falkner	Fogle	Fowler
Gallick	Gragg	Griffith	Haden	Hales
Haley	Harbison	Hardwick	Hausman	Hein
Hewkin	Hinman	Hruza	Hurlbert	Ingle
Irwin	Jacobs	Jamison	Jobe	Johnson
Jones 88	Jordan	Justus	Kalberloh	Keathley
Kelley	Kimble	Knight	Laubinger	Lewis
Loy	Lucas	Mackey	Mansur	Martin
Matthiesen	Mayhew	McGaugh	McGirl	Miller
Mosley	Murphy	Murray	Myers	Nolte
Oehlerking	Overcast	Owen	Perkins	Peters

Phelps	Plank	Pollitt	Pouche	Price
Reed	Reedy	Reuter	Riggs	Riley
Roberts	Rush	Sassmann	Schmidt	Schulte
Seitz	Self	Sharpe 4	Simmons	Smith 46
Smith 68	Smith 74	Sparks	Steinhoff	Steinmetz
Steinmeyer	Stinnett	Strickler	Taylor 48	Taylor 84
Terry	Thomas	Titus	Van Schoiack	Veit
Vernetti	Violet	Voss	Waller	Walsh Moore
Warwick	Weber	Wellenkamp	Williams	Wilson
Wolfin	Woods	Young	Zimmermann	Mr. Speaker

NOES: 001

Collins

PRESENT: 001

Fountain Henderson

ABSENT WITH LEAVE: 020

Appelbaum	Aune	Banderman	Boggs	Bosley
Cupps	Ealy	Farnan	Fuchs	Hovis
Jones 12	Meirath	Parker	Proudie	Sharp 37
Shields	Thompson	West	Whaley	Wright

VACANCIES: 001

Speaker Pro Tem Perkins assumed the Chair.

HOUSE RESOLUTIONS

Representative Dolan offered House Resolution No. 164.

INTRODUCTION OF HOUSE JOINT RESOLUTIONS

The following House Joint Resolutions were read the first time and copies ordered printed:

HJR 79, introduced by Representative Parker, relating to retrospective laws involving civil childhood sexual abuse claims.

HJR 80, introduced by Representative Simmons, relating to ballot measures submitted to voters.

INTRODUCTION OF HOUSE BILLS

The following House Bills were read the first time and copies ordered printed:

HB 1130, introduced by Representative Loy, relating to titles or designations reserved for the use of licensed physicians.

HB 1131, introduced by Representative Parker, relating to nondisclosure agreements in childhood sexual abuse cases.

HB 1132, introduced by Representative Parker, relating to civil actions for childhood sexual abuse, with a contingent effective date.

HB 1133, introduced by Representative Martin, relating to the ground ambulance service reimbursement allowance tax.

HB 1134, introduced by Representative Doll, relating to trial procedures for murder in the first degree.

HB 1135, introduced by Representative Falkner, relating to underground telecommunications facilities, with penalty provisions.

HB 1136, introduced by Representative Byrnes, relating to the digital assets authorization act.

HB 1137, introduced by Representative Cook, relating to jurisdiction over Missouri land.

HB 1138, introduced by Representative Reuter, relating to pyramid sales schemes.

HB 1139, introduced by Representative Reuter, relating to associate circuit judges in the twenty-third judicial circuit.

HB 1140, introduced by Representative Reuter, relating to a cause of action based on alienation of affection.

HB 1141, introduced by Representative Christ, relating to peer-to-peer car-sharing programs, with a delayed effective date.

HB 1142, introduced by Representative Jones (12), relating to offenses involving sexual trafficking of children, with penalty provisions.

HB 1143, introduced by Representative Woods, relating to same-day voter registration.

HB 1144, introduced by Representative Seitz, relating to reproductive health care.

HB 1145, introduced by Representative Diehl, relating to certain civil remedies for unlawful discriminatory practices.

HB 1146, introduced by Representative Justus, relating to reconsideration of library materials.

HB 1147, introduced by Representative Phelps, relating to collecting the immigration status of criminal offenders.

HB 1148, introduced by Representative Byrnes, relating to the 988 Lifeline.

HB 1149, introduced by Representative Byrnes, relating to dual diagnosis treatment centers, with penalty provisions.

HB 1150, introduced by Representative Hausman, relating to unregulated child custody transfers, with penalty provisions.

HB 1151, introduced by Representative Jobe, relating to terms of imprisonment.

HB 1152, introduced by Representative Simmons, relating to campaign finance, with penalty provisions.

HB 1153, introduced by Representative Williams, relating to certificates of license to teach.

SECOND READING OF HOUSE JOINT RESOLUTIONS

The following House Joint Resolutions were read the second time:

HJR 76, relating to state revenue.

HJR 77, relating to constitutional amendments.

HJR 78, relating to ballot measures submitted to voters.

SECOND READING OF HOUSE BILLS

The following House Bills were read the second time:

HB 1103, relating to adoption, with a penalty provision.

HB 1104, relating to county hospitals.

HB 1105, relating to requirements for certain political subdivisions.

HB 1106, relating to the designation of a memorial highway.

HB 1107, relating to the sales and use tax imposed on certain products.

HB 1108, relating to the official state cheese.

HB 1109, relating to home school protections.

HB 1110, relating to adult high schools.

HB 1111, relating to STEM career awareness.

HB 1112, relating to income tax.

HB 1113, relating to earned wage access services, with penalty provisions.

HB 1114, relating to driver's license requirements.

HB 1115, relating to proceedings resulting from criminal conduct.

HB 1116, relating to fences and enclosures.

HB 1117, relating to railroad safety, with penalty provisions.

HB 1118, relating to abuse-deterrent opioid analgesic drug products.

HB 1119, relating to abortion, with penalty provisions.

HB 1120, relating to pyramid sales schemes.

HB 1121, relating to the procurement of driving data by automobile insurers.

HB 1122, relating to coroners.

HB 1123, relating to the statewide assessment system, with a contingent effective date for certain sections.

HB 1124, relating to wind energy conversion systems.

HB 1125, relating to documents presented for recording.

HB 1126, relating to insurance coverage of anesthesia services.

HB 1127, relating to credit for time served.

HB 1128, relating to political party primary elections, with penalty provisions and a delayed effective date.

HB 1129, relating to law enforcement agency reporting requirements.

REFERRAL OF HOUSE ELECTION CONTESTS

The following House Election Contest was referred to the Committee indicated:

HEC 1 - Elections

REFERRAL OF HOUSE JOINT RESOLUTIONS

The following House Joint Resolutions were referred to the Committee indicated:

HJR 7 - Ways and Means
HJR 25 - Judiciary
HJR 46 - Government Efficiency

REFERRAL OF HOUSE BILLS

The following House Bills were referred to the Committee indicated:

HB 32 - Elementary and Secondary Education
HB 37 - Special Committee on Tourism
HB 44 - Pensions
HB 49 - Crime and Public Safety
HB 57 - Insurance
HB 63 - Special Committee on Tourism
HB 64 - Special Committee on Tourism
HB 65 - Special Committee on Tourism
HB 69 - Commerce
HB 72 - Local Government
HB 87 - Crime and Public Safety
HB 107 - Special Committee on Tourism
HB 116 - Elementary and Secondary Education
HB 122 - Corrections and Public Institutions
HB 126 - Elections
HB 131 - Judiciary
HB 138 - Legislative Review
HB 144 - Local Government
HB 170 - Corrections and Public Institutions
HB 176 - General Laws
HB 178 - General Laws
HB 182 - Judiciary
HB 183 - Higher Education and Workforce Development
HB 195 - Health and Mental Health
HB 196 - General Laws
HB 209 - Emerging Issues
HB 211 - Agriculture
HB 218 - Transportation
HB 224 - General Laws
HB 239 - Transportation
HB 263 - Judiciary
HB 271 - General Laws
HB 284 - Special Committee on Urban Issues
HB 290 - Special Committee on Intergovernmental Affairs
HB 291 - Higher Education and Workforce Development

HB 309 - Insurance
HB 313 - Local Government
HB 315 - Government Efficiency
HB 331 - Higher Education and Workforce Development
HB 333 - Elections
HB 341 - Government Efficiency
HB 350 - Children and Families
HB 362 - Crime and Public Safety
HB 388 - Local Government
HB 397 - Professional Registration and Licensing
HB 398 - Health and Mental Health
HB 414 - Elections
HB 417 - General Laws
HB 437 - Commerce
HB 443 - Local Government
HB 457 - Legislative Review
HB 478 - Professional Registration and Licensing
HB 479 - Elections
HB 493 - Ways and Means
HB 497 - Insurance
HB 498 - Elementary and Secondary Education
HB 499 - Special Committee on Tax Reform
HB 515 - Ways and Means
HB 520 - Government Efficiency
HB 530 - Insurance
HB 531 - Ways and Means
HB 553 - Health and Mental Health
HB 555 - Commerce
HB 561 - Government Efficiency
HB 567 - Commerce
HB 569 - Utilities
HB 570 - Children and Families
HB 596 - Financial Institutions
HB 606 - Higher Education and Workforce Development
HB 607 - Special Committee on Intergovernmental Affairs
HB 608 - Financial Institutions
HB 613 - Children and Families
HB 622 - Local Government
HB 626 - Insurance
HB 632 - General Laws
HB 635 - Ways and Means
HB 636 - Special Committee on Tourism
HB 656 - Elementary and Secondary Education
HB 661 - Transportation
HB 663 - Judiciary
HB 665 - Transportation
HB 684 - Elections

HB 714 - Veterans and Armed Forces
HB 734 - Special Committee on Tourism
HB 736 - Judiciary
HB 738 - General Laws
HB 744 - Elementary and Secondary Education
HB 749 - Local Government
HB 752 - Utilities
HB 754 - Financial Institutions
HB 771 - Commerce
HB 775 - Transportation
HB 778 - Special Committee on Intergovernmental Affairs
HB 783 - Ways and Means
HB 784 - Health and Mental Health
HB 794 - Commerce
HB 838 - Legislative Review
HB 839 - Judiciary
HB 840 - Health and Mental Health
HB 857 - Legislative Review
HB 859 - Ways and Means
HB 868 - Government Efficiency
HB 897 - Commerce
HB 916 - Corrections and Public Institutions
HB 918 - Commerce
HB 950 - Transportation
HB 952 - Commerce
HB 958 - Commerce
HB 971 - Transportation
HB 974 - Insurance
HB 977 - Pensions
HB 978 - Transportation
HB 982 - Health and Mental Health
HB 987 - Elections
HB 988 - Special Committee on Tax Reform
HB 1007 - Special Committee on Tax Reform
HB 1017 - Higher Education and Workforce Development
HB 1018 - Government Efficiency
HB 1025 - Children and Families
HB 1032 - Insurance
HB 1035 - Transportation
HB 1044 - Elementary and Secondary Education
HB 1048 - Transportation
HB 1066 - Crime and Public Safety
HB 1069 - Government Efficiency
HB 1074 - Elementary and Secondary Education
HB 1086 - Ways and Means
HB 1116 - Agriculture
HB 1119 - Health and Mental Health

RE-REFERRAL OF HOUSE BILLS

The following House Bill was re-referred to the Committee indicated:

HB 858 - Transportation

COMMITTEE REPORTS

Committee on Crime and Public Safety, Chairman Myers reporting:

Mr. Speaker: Your Committee on Crime and Public Safety, to which was referred **HB 117**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute** by the following vote:

Ayes (15): Banderman, Cook, Hovis, Irwin, Jones (88), Myers, Phelps, Price, Schulte, Seitz, Sharp (37), Sparks, Violet, Williams and Zimmermann

Noes (2): Anderson and Bosley

Present (1): Collins

Absent (2): Taylor (48) and West

Mr. Speaker: Your Committee on Crime and Public Safety, to which was referred **HB 225**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (12): Banderman, Cook, Hovis, Irwin, Jones (88), Myers, Phelps, Schulte, Seitz, Sparks, Violet and Williams

Noes (4): Bosley, Collins, Price and Zimmermann

Present (2): Anderson and Sharp (37)

Absent (2): Taylor (48) and West

Mr. Speaker: Your Committee on Crime and Public Safety, to which was referred **HB 495**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute** by the following vote:

Ayes (13): Banderman, Cook, Hovis, Irwin, Jones (88), Myers, Phelps, Schulte, Seitz, Sparks, Violet, West and Williams

Noes (6): Anderson, Bosley, Collins, Price, Sharp (37) and Zimmermann

Absent (1): Taylor (48)

REFERRAL OF HOUSE BILLS - RULES

The following House Bills were referred to the Committee indicated:

HCS HB 75 - Rules - Administrative
HCS HB 425 - Rules - Administrative
HCS HBs 594 & 508 - Rules - Administrative
HCS HBs 595 & 343 - Rules - Administrative
HCS HBs 737 & 486 - Rules - Administrative
HB 742 - Rules - Administrative

REPORT OF THE TASK FORCE ON SUBSTANCE ABUSE PREVENTION AND TREATMENT

January 27, 2025

Jonathan Patterson, Speaker
House of Representatives
State Capitol Building
Jefferson City, MO 65101

Cindy O'Laughlin, President Pro Tempore
Missouri Senate
State Capitol Building
Jefferson City, MO 65101

Dear Mister Speaker and Madam President Pro Tempore:

The Task Force on Substance Abuse Prevention and Treatment authorized in Section 21.790 of the Revised Statutes of Missouri, has met and held hearings and taken testimony. The attached Task Force report addresses the subjects set forth in Section 21.790.3, and includes recommendations for current and future legislation sessions with regard to funding and legislation. All current Task Force members are listed following, with signature indicting approval of the attached report. Thank you for your attention to these issues significant to the people of Missouri.

/s/ Chairman Representative John Black
/s/ Representative LaDonna Appelbaum
/s/ Representative Dave Griffith
/s/ Representative Melanie Stinnett
/s/ Representative Del Taylor
/s/ Representative Dale Wright
/s/ Rodney Hummer
Vacant

/s/ Vice Chairman Nick Schroer
/s/ Senator Rusty Black
Vacant
/s/ Senator Karla May
/s/ Senator Angela Mosley
/s/ Senator Brian Williams
/s/ Phillip Ohlms
/s/ Rachel Winograd

AUTHORS

Representative John Black, Missouri State Legislator, SAPT Task Force Member
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Isabel Warner, Ph.D., MOST Policy Initiative Legislative Policy Fellow
Maryluz E. Hoyos, Ph.D., MOST Policy Initiative Legislative Policy Fellow
Chinenye Izuegbunam, Ph.D., MOST Policy Initiative Legislative Policy Fellow
Chris Wielga, Ph.D., MOST Policy Initiative Legislative Policy Fellow
Representative Del Taylor, Missouri State Legislator, SAPT Task Force Member

FOREWORD

This is the second report of the Missouri statutorily authorized Substance Abuse Prevention and Treatment Task Force. The goal of this report is to continue to provide an overview of the efforts of the state of Missouri to address

the tragedy of substance use, both from a financial and programmatic perspective, and to summarize our findings and recommendations. The basic format of the first report will be followed, with updated data.

In the five evidentiary hearings this summer and fall, the task force heard hours of expert testimony from seven state departments and multiple organizations that implement multiple programs to combat substance misuse. Details of programs were compiled and used to generate charts, tables, and the budget overview. Hearing testimony is summarized and formed the basis for recommended next steps. The appendix contains over 170 pages of programmatic and budgetary information provided by the state departments, as well as organizations receiving state funding.

As before, this report of the Substance Abuse Prevention and Treatment Task Force has relied heavily on the House of Representatives Research staff, and particularly Colin Zentmeyer, who provided excellent summaries of witness testimony, as well as analysis provided by the Missouri MOST Policy Initiative and would have been impossible without the significant cooperation of the state departments and participation of task force members.

Special thanks to task force member Del Taylor (District 84) who actively participated in all hearings, designed this report's templates, guided MOST Fellow efforts and contributed to the content and final editing of this document.

MOST Fellows Drs. Rieka Yu, Isabel Warner, Maryluz Hoyos, Chinenye Izuegbunam and Chris Wielga contributed hours organizing department data into a useful document.

The participating state departments have been offered the opportunity for review prior to issuing the final report, and most provided helpful corrections.

This report is provided for the benefit of the people of Missouri, with direct intended audience of the Office of the Governor, and the General Assembly, to support the best use of limited state resources in combatting this life destroying plague.

John Black, Task Force Chair, 102nd General Assembly, State of Missouri.

TASK FORCE MEMBERS

- Senate Members
    - Rusty Black, Senate District 12
    - Vacant
    - Karla May, Senate District 4
    - Angela Mosley, Senate District 13
    - Nick Schroer, Task Force Vice Chair, Senate District 2
    - Brian Williams, Senate District 14
- House of Representatives Members
    - LaDonna Appelbaum, House District 71
    - John Black, Task Force Chairman, House District 129
    - Dave Griffith, House District 60
    - Melanie Stinnett, House District 133
    - Del Taylor, House District 84
    - Dale Wright, House District 116
- Governor Appointees
    - Rodney Hummer, Vice President of Strategy, Missouri Primary Care Association
    - Philip Ohlms, Associate Judge (Ret.), 11th Judicial Circuit Court of Missouri
    - Vacant
    - Dr. Rachel Winograd, Associate Professor, University of Missouri – St. Louis

AUTHORIZING STATUTE

Title III LEGISLATIVE BRANCH
Chapter 21 Effective – 28 Aug 2019

21.790. Task force established, members — duties — report. — 1. There is hereby established the "Task Force on Substance Abuse Prevention and Treatment". The task force shall be composed of six members from the house of representatives, six members from the senate, and four members appointed by the governor. The senate members of the task force shall be appointed by the president pro tempore of the senate and the house members by the speaker of the house of representatives. There shall be at least two members from the minority party of the senate and at least two members from the minority party of the house of representatives. The members appointed by the governor shall include one member from the health care industry, one member who is a first responder or law enforcement officer, one member who is a member of the judiciary or a prosecuting attorney, and one member representing a substance abuse prevention advocacy group.

2. The task force shall select a chairperson and a vice-chairperson, one of whom shall be a member of the senate and one a member of the house of representatives. A majority of the members shall constitute a quorum. The task force shall meet at least once during each legislative session and at all other times as the chairperson may designate.

3. The task force shall:

(1) Conduct hearings on current and estimated future drug and substance use and abuse within the state;

(2) Explore solutions to substance abuse issues; and

(3) Draft or modify legislation as necessary to effectuate the goals of finding and funding education and treatment solutions to curb drug and substance use and abuse.

4. The task force may make reasonable requests for staff assistance from the research and appropriations staffs of the senate and house of representatives and the joint committee on legislative research. In the performance of its duties, the task force may request assistance or information from all branches of government and state departments, agencies, boards, commissions, and offices.

5. The task force shall report annually to the general assembly and the governor. The report shall include recommendations for legislation pertaining to substance abuse prevention and treatment.

(L. 2019 S.B. 514)

EXECUTIVE SUMMARY

$8.5 billion dollars. $3.5 billion dollars. The human costs of substance use disorders to individuals and families are incalculable, undefinable in monetary terms. There are estimated financial costs to the State of Missouri reported. The Department of Mental Health estimates the annual societal costs of substance use/misuse to Missouri range from $8.5 billion to $12 billion, for illicit substances, prescription drugs, alcohol, and tobacco. The American Cancer Society estimates the use of tobacco direct health care costs in Missouri at $3.5 billion, including over $690 million in annual Medicaid costs. The total of those costs, not including the $7 Billion lost in annual productivity due to smoking additionally estimated by the Cancer Society, therefore exceeds $12 billion. By comparison, the 2024 fiscal year individual income tax paid by Missourians totaled $9.8 billion. In other words, the cost to Missourians due to the use of addictive substances exceeds the total amount of individual income taxes paid to the state. By further comparison, of the $96,000,000 of tobacco settlement funds estimated to be received in FY 2025 by Missouri, $350,000 is budgeted to be added on to the Department of Social Services' tobacco addiction prevention and cessation, or .36% of the tobacco settlement funds spent on prevention. And compared to the $8,500,000,000 in costs due to substance use/misuse, approximately $125,000,000 is spent on prevention (that figure is inflated due to inclusion of treatment costs), or 1.4% of the societal costs to Missouri.

After a period of increase between 2013 and 2022, rates of drug overdose deaths involving synthetic opioids other than methadone, which includes fentanyl, fentanyl analogs, and tramadol, decreased between 2022 and 2023.The total number of all drug overdose deaths in 2021 was 106,699, and in 2023, 105,007 drug overdose deaths occurred, resulting in an age-adjusted rate of 31.3 deaths per 100,000 standard population.[1] By comparison, 58,220 American

[1] National Institutes of Health. (2023). Drug Overdose Death Rates. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

soldiers were killed in the Vietnam War.[2] Overdose is the leading cause of death for adults 18-44 in MO, and of the 1,948 deaths from overdose in 2023, 73% were contributed to opioids. In 2022, death rate was 9.1% higher than US rate of overdose deaths. Data from 2019-2021 about maternal mortality indicates about 28% of pregnancy related deaths have substance use disorder as a contributing factor. In 2022, 6275 nonfatal emergency room visits from drug overdoses were non-opioid, which was 60% of all drug overdose emergency room visits. 37% of which were self-harm. Why is this important? The burden of overdose impacts families, communities, and health care systems. (2) As a result of factors hard to quantify but undoubtedly including additional programs and distribution of Naloxone (trade name Narcan) overdose deaths are decreasing (11% in 2023). Only sustained effort, including funding, will continue this positive trend. (2) (14)

Per the National Survey on Drug Use and Health (NSDUH) prevalence estimates, approximately 943,000 Missourians aged 12 and over struggled with a substance use disorder in the past year. This amounts to nearly one sixth of the Missouri population, and approximately 20% of the adult population. Of those estimated to have a substance use disorder, 536,000 Missourians struggled with alcohol use disorder.

Deaths in Missouri from substance use include approximately 10,000 smoking-related; more than 1500 opioid-involved; over 700 methamphetamine-involved; and 910 alcohol-involved in 2022. (Table 1 and Figure 1 page 16).

The Task Force continues to attempt to analyze spending to address substance use, an effort not found elsewhere, and likely to be somewhat inaccurate as result of the difficulty of the accumulating budget information, but beneficial to address the relative costs of the problem and the response. Two different perspectives are offered, the first on a substance-by-substance analysis, and the second by program (prevention, versus treatment, including recovery). Per substance, Missouri spends the most on programs addressing all substances ($244 million in FY 25 funding) (Table 2, Figure 2, pages 18, 17).

By a program analysis, the amount spent in Missouri in FY 2024 on substance use disorder is estimated at approximately $308 million, with the appropriation for FY 2025 to be approximately $431 million, (Table 4, page 24). This compares to the state budgets of $51.8 billion and $50.5 billion for FY24 and FY25, respectively, or the percentage of expenditure being 0.59% and 0.85%, respectively, of the total spent during each fiscal year. (All figures include both federal and state funds.) The question remains whether these percentages of the state budget spent on substance use is an adequate expenditure.

Per the Department of Health and Senior Services, programs addressing tobacco use, the leading cause of death, in FY 2025 are budgeted at $4.8 million, of the approximately $431 million dollar total. Cigarette smoking is the leading cause of preventable disease, disability, and death in the US. Department testimony:

- Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined;
- 11,000 Missourians die each year from smoking related illnesses;
- 1,150 Missouri adults die each year from exposure to secondhand smoke
- Missouri spends $3.5 billion annually to treat smoking-related diseases and $7.1 billion on lost productivity
- Missouri ranks 7 in the country for the number of adults who smoke
- Missouri has the lowest tobacco tax in the country, ranked 51st, at $0.17 per pack of cigarettes (national average is $1.83 per pack, next lowest is Georgia at $0.36 per pack).
- Missouri's Medicaid has the best access to cessation services in the country, with access to all 7 evidence-based medications.

In its follow-up testimony, the DHSS identified Smoke Free Air Laws in 28 states that do not allow smoking in public places, correlating to preventing tobacco use initiation and use, reduced secondhand smoke exposure, and prevalence of tobacco use and up to a 70% reduction is hospital heart attack admissions. Tobacco free school district policies have similar results. (2)

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[2] National Archives. (n.d.). Vietnam War U.S. Military Fatal Casualty Statistics. https://www.archives.gov/research/military/vietnam-war/casualty-statistics#:~:text=April%2029%2C%202008.-,The%20Vietnam%20Conflict%20Extract%20Data%20File%20of%20the%20Defense%20Casualty,and%20Records%20Administration%20in%202008

One issue is how much is spent on prevention versus treatment. Table 4, on page 24, attempts to address that question by identifying that approximately 65% of the funding is spent on treatment.

Missouri continues to provide a comprehensive approach with the funding available. Table 5, on page 29, breaks down the spending between the state departments, with the Department of Mental Health (DMH) receiving approximately 70% of the funding. DMH is the state authority for coordinating a statewide response to substance use disorders. The Department of Health and Senior Services (DHSS) receives approximately 12% of the FY 2025 budget, a significant increase due in part to the recreational marijuana tax designated to that department, with a significant portion passed on to DMH. The Department of Social Services (DSS) funding identified is largely due to the MO Health (Medicaid) pharmacy program. The total identified is misleading as much of the DMH and DHSS funding is a pass-through from Medicaid. The Department of Corrections (DOC) is to receive about 6% of the substance use funding in FY 25.

Figure 3, on page 20, charts the number of programs per department, with DMH at 31 and DHSS at 21. The largest source of funding for substance use disorders is ultimately MO HealthNet (Medicaid) as a result of the percentage of participants that are Medicaid-eligible.

Encouraging are the new programs for FY 2025 itemized in Table 3, Pages 21-22, as Missouri continues to focus on needed and effective programs. The departments are encouraged to utilize and tabulate for themselves and the legislature the significant amount of data required to be reported to the federal government, which could be utilized in determining program effectiveness.

There are other encouraging signs. The first is the increase in budgeted funding in FY 2025. The task force recognizes FY 2026 may be a challenging year fiscally, and its first recommendation is that funding be at least maintained and that identified effective programs receive additional support. A few of the positive programs and initiatives are identified as follows:

MO HealthNet continues to support an open access policy, progressive in its efforts to treat substance use. One example is its support of the Federally Qualified Health Center Network program, new in FY 2024, which emphasizes effective time to treatment and comprehensive services. In fiscal year 2024, Network patients have expanded from 1031 in quarter two, to 2494 in quarter four. (4)(9)

988. The call, chat, or text program to allow persons to get immediate direction to treatment continues to expand and is identified by the DMH as ‘vital”, receiving over 95,000 phone calls, 15,000 texts and 5800 chats in FY 2024. (1).

Behavioral Health Crisis Centers, another new program and referral to treatment programs, served over 41,000 people in fiscal year 2024. (1).

Engaging Patients in Care Coordination (EPPIC) provides a 24/7 referral and linkage to service for people who use drugs who present at a hospital for overdose or substance use crisis to establish immediate connections from the hospital to community level care, with 390 average referrals per month. (1) (11)

Certified Community Behavioral Health Clinics (CCBHC) and Comprehensive Substance and Treatment Rehabilitation (CSTAR) programs continue to increase prescribers and move to comprehensive, effective time to treatment programs, treating more than 218,000 people and 26,000 in the last reporting year, with 11,000 and 3600 persons in substance use disorder (SUD) treatment, respectively. (1)

Recovery Support Providers, including Recovery Support Services and Recovery Community Centers, are identified by DMH as a “big bang for the buck”. Together, they provide recovery services, sober housing, employment assistance, education support, and transportation, with statistics including an 84% abstinence from alcohol and drugs, 97% in stable housing, 73% employed or in school and 98% with no arrests in 30 days; and providing accredited recovery housing, with 2300 beds expanded by 624 new beds in 2023. The program requests $6 million additional funding to provide more services and another $3 million to open new centers in underserved areas. (1)(13)

Department of Corrections, reports a drop in recidivism rates since 2008 from 44% to 30%, supported by its newly implemented Individualize treatment programmatic efforts, and including individualize treatment programs with emphasis on reentry services including Medically Assisted Treatment. (5)

Office of State Courts Administrator, with the Treatment Courts Coordinating Commission and treatment under what is commonly known as Drug Treatment Courts, supporting specified legislation for Mental Health courts, and additional funding focusing on Medication Assisted Treatment for opioid and alcohol addiction. (7)

Collaboration continues to be emphasized around the state. For example, in Southwest Missouri, coordination between the CCBHC Burrell and the Webster County Public Health agency, establishing a community partnership, saw a backlog 80 students waitlisted for behavioral health services, frequently associated with substance use, eliminated in one month. (17)

Challenges. The Department of Mental Health, Department of Corrections, the University of Missouri – St. Louis Addiction Science Team and the Department of Health and Senior Services agree the most urgent and difficult to solve problems are transportation and housing. This is one reason for the strong support by DMH of Recovery Support Providers, and their accredited recovery housing program. Other identified challenges include:

Medicaid, the most common source of payment, does not provide funding for prevention or recovery, only treatment. Prevention and recovery funding is thus limited to federal grants and general revenue, and more recently, opioid settlement and adult use (recreational) marijuana tax. (1)

DMH, in addition to transportation and housing, identifies jail services, a need for additional crisis centers, and a "crushing" workforce shortage as significant challenges, as well as the continuing need for community and youth liaisons, and certified peer specialists. (1) Improving timing of care is illustrated by DHSS testimony that of the 815 suspected overdose cases identified in August 2024, 498 occurred outside normal business hours.

Prevention training is hampered by the fact that death investigations are decentralized the Missouri, as a result coroners and medical examiners did not report to a single entity for oversight and death investigations such as drug overdose reporting and pregnancy associated mortality review are not connected. (2)

Communicable disease transmission, often associated with drug use, is increasing. Syphilis cases in Missouri increased by 230% from 2016 to 2022. Viral hepatitis and syphilis are increasing in rural Missouri, compounded by injection methamphetamine use. Congenital syphilis has increased from two cases in 2017 to 94. Increase funding for doxycycline is requested by DHSS. (2)

Health Professional shortages, specifically including mental health training for physicians results in an estimated one in seven people diagnosed with substance use disorder receiving treatment. Missouri has a 900 health professionals' shortage, including 350 medical residents. Missouri exports nearly 1/3 of its medical students to residency programs in other states. (2)

Transportation for persons who need treatment could be supported by expansion of a pilot program to allow emergency personnel to be reimbursed for transportation to an alternative destination, and in home consultations. The pilot program showed a net savings per intervention of over $500 per intervention. (14).

Limitations on syringe services programs, identified by DHSS and the University of Missouri – St. Louis Addiction Science Team, who reported that concerns of increasing substance use because of such programs being enacted are not supported by evidence in many other states. The CDC states that syringe services programs are proven and effective community-based prevention programs that can provide a range of services, including access to treatment, housing, and transportation. (1) (2) (14)

Standardization of tax credits for the Neighborhood Assistance Program in the Youth Opportunity Program to equal those supporting pregnancy care centers would support the activities of organizations such as Catholic Charities St. Louis, which programs serve over 1000 persons per year, many of those with mental health and SUD issues. (18)

Lack of transparency in sentencing challenges courts and corrections in establishing drug treatment and release, Missouri having one of the most complicated sentencing laws in the country. (5)

RECOMMENDATIONS

Table 9: Recommendations
Part 1: Recommendations for Fiscal Year 2026 and Following:

1) Review whether the current level of funding for substance use prevention and treatment is adequate to continue to build treatment capacity across the state; DMH reports that demand far exceeds capacity, so the question remains where targeted investments would offer the most return;
2) At a minimum, even in difficult financial times, continue the current level of funding;
3) State departments address and implement and/or make recommendations to the legislature for methods for improved transportation and housing
4) Provide additional funding for the programs identified as particularly effective:
    a. 988
    b. Behavioral health crisis centers
    c. Recovery support service providers;
    d. Programs offering comprehensive and reduced time to treatment, including EPICC and FQHCs and CCBHCs;
    e. Judicial treatment courts, including mental health and veterans' courts;
    f. Department of Corrections individualized treatment and reentry
    g. Community and Youth Services liaisons; and
    h. Improve Medicaid coding to better track expenditures and services
    i. State public defenders
5) Continue to evaluate spend, emphasizing prevention;
6) Continue to utilize cannabis tax and opioid settlement funds for promising programs like mentoring, school-based supports, youth crisis centers, etc.
7) Increase prevention funding for tobacco and alcohol addiction prevention, and for tobacco, increase the use of the tobacco settlement funding.
8) Review transportation resources, including continuation/expansion of a pilot program to allow emergency responders to receive funding to alternative destinations and in-home consults.
9) Pursue transparency in sentencing.
10) Address the additional concerns listed in this summary.

Part 2: The following 2025 Recommendations for Subjects for Future Task Force Investigation are continued:

1) Determine measures and metrics for effectiveness, to include SUD incarceration and over-dose rates and returns on investments in other states;
2) Address subjects, which may have been previously controversial among the General Assembly, that have demonstrated effectiveness in other states, including:
    a. Raising the tobacco tax;
    b. Ensuring compliance with federal and state tobacco laws;
    c. Optimizing the use of tobacco settlement funds; and
    d. Implementing needle exchange programs;
3) Examine the need for and methods of providing wraparound services, including housing, expansion of rental assistance and community re-entry from incarceration/federal Medicaid re-establishment/exclusion waiver, and application of the sequential intercept model;
4) Continue to encourage departments to engage in evidence-based practices, with continued reporting and recommendations to the General Assembly, such as evidence-based prevention education and evolving/cutting edge evidence-based treatment methodologies linking mental health and substance use;
5) Examine the long-term impacts of recreational cannabis use in Missouri; and
6) Review and consider the Policy Research included in this report regarding the Public Health Outcomes of Cannabis Legislation, Tobacco Taxes in Other States, and Syringe Service Programs, provided by the non—partisan MOST Policy Research at the request of the task force chair. The Report Details and

Summaries of Witness Testimony, as well as the department summaries and supplemental information in the appendices are recommended.

The pages of materials included as Exhibits in this report, offered by the departments and organizations testifying before the Task Force, provide a wealth of detailed information. It would be difficult if not impossible to find a more comprehensive compendium regarding the subject, at least in Missouri, and those materials are therefore highly recommended, and can be found online to the Journal of Missouri House of Representatives on the date of publication of this report in the Journal.

References cited in this Executive Summary are as follows:

1) Department of Mental Health
2) Department of Health and Senior Services
3) Department of Social Services
4) Mo HealthNet
5) Department of Corrections
6) Missouri Supreme Court/Office of State Courts Administrators
7) Missouri State Public Defender
8) Missouri Primary Care Association
9) Department of Elementary and Secondary Education
10) EPICC
11) American Cancer Society
12) Missouri Coalition of Recovery Support Providers
13) Washington University
14) University of Missouri – St. Louis Addiction Science Team
15) Brightli Southwest Region
16) Webster County Public Health Unit
17) Catholic Charities of St. Louis

REPORT DETAILS

Deaths by Substance

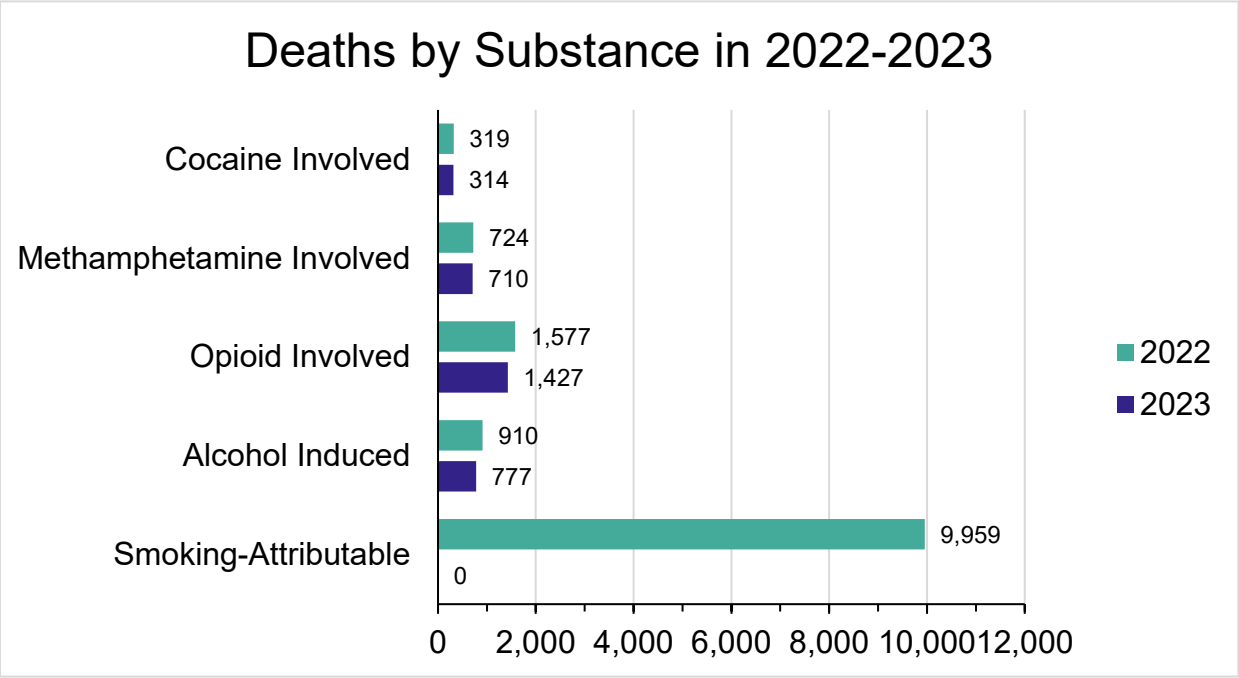

Figure 1. Number of deaths in Missouri per addictive substance. Data provided by DHSS for 2022 and 2023.

Table 1. Number of deaths in Missouri per addictive substance. Data provided by DHSS for 2022. (See Figure 1).

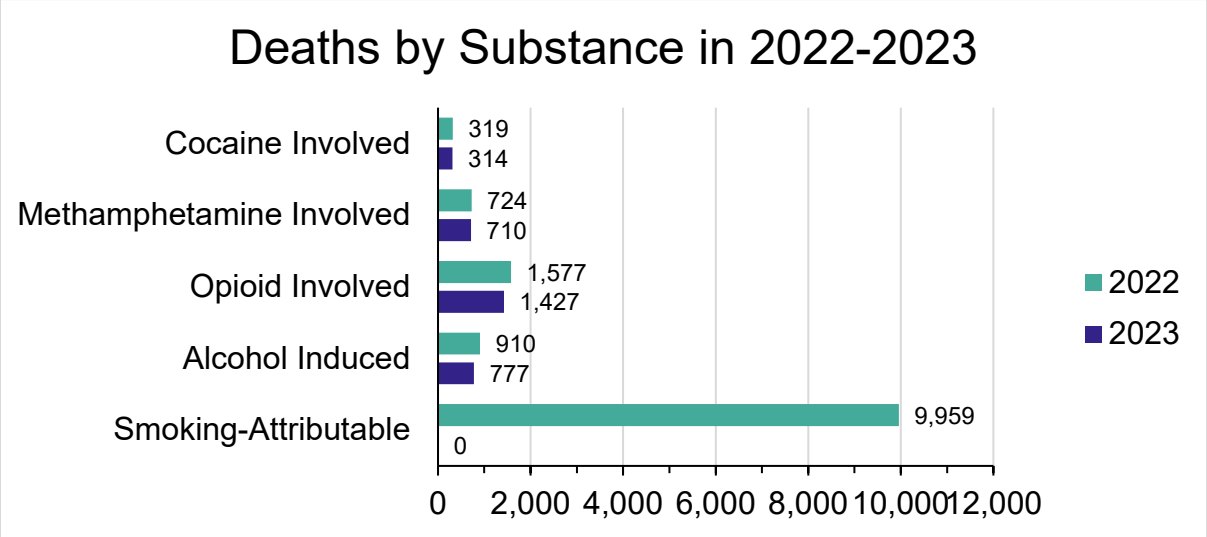

Figure 1

Cause***	Deaths (2023)	Deaths (2022)
Smoking-Attributable*	Still unknown	9,959
Alcohol Induced**	777	910
Opioid Involved	1427	1,577
Methamphetamine Involved	710	724
Cocaine Involved	314	319

*Derived from a formula that assigns a certain percentage of various causes of death to tobacco smoking. Smoking also attributes to heart disease, cancer, and chronic lower respiratory disease, all of which are the three highest leading causes of death in Missouri. Secondhand smoke is also a significant cause.

** A broad definition that includes: alcohol induced pseudo-Cushing's syndrome; mental and behavioral disorders due to use of alcohol; degeneration of nervous system due to alcohol; alcoholic polyneuropathy; alcoholic myopathy; alcoholic cardiomyopathy; alcoholic gastritis; alcoholic liver disease; alcohol induced pancreatitis (chronic and acute); fetal induced alcohol syndrome (dysmorphic); excess alcohol blood levels; accidental poisoning by and exposure to alcohol (intentional, accidental, or undetermined intent); fetal alcohol syndrome.

***Drug types are not mutually exclusive, meaning a death record may have more than one drug listed, and would therefore be counted in both categories.

Funding

To assess these deaths and related substance use disorders (SUDs), the state of Missouri has appropriated funds to programs aimed at treatment, recovery, and prevention, as well as to support the associated administrative costs to run these programs. Per substance, Missouri spends the most on programs addressing all substances ($244 million). (Table 2**,** Figure 2).

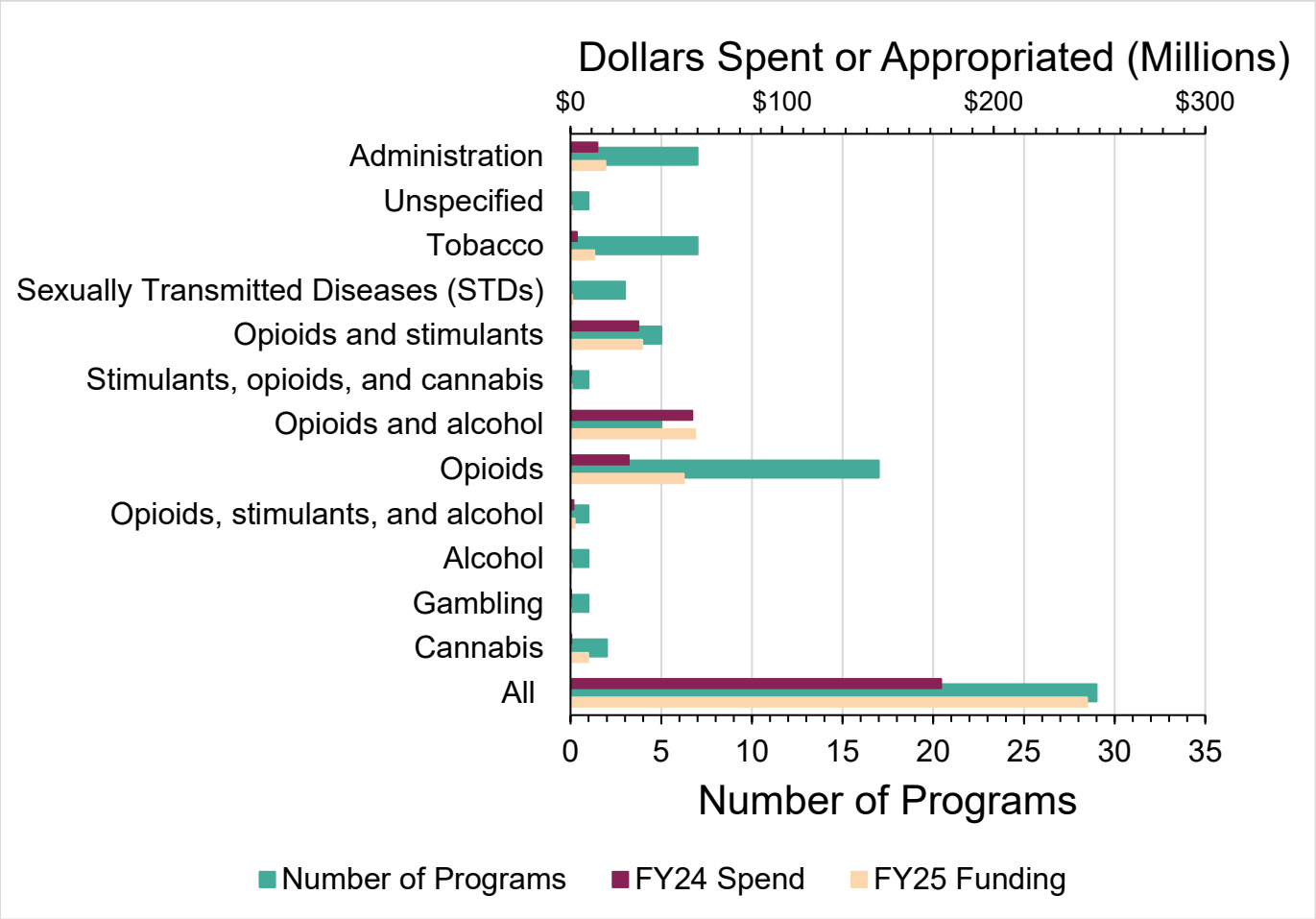

Figure 2. State funding dedicated to each addictive substance based on the number of programs dedicated to specific substances.

Table 2. State funding dedicated to programs working with SUDs related to each addictive substance. (See Figure 2)

Substance	Number of Programs	FY25 Funding	FY24 Spend	Additional Amount Appropriated
All*	29	$244,160,464	$175,079,011.08	$69,081,452.92
Cannabis	2	$8,348,619.00	$328,638.00	$8,019,981.00
Gambling	1	$153,606.00	$3,819.00	$149,787.00
Alcohol	1	$500,000.00	$0.00	$500,000
Opioids, stimulants, and alcohol	1	$1,899,877.00	$1,444,526.00	$455,351.00
Opioids**	17	$53,467,391.00	$27,451,278.33	$26,016,112.67
Opioids and alcohol	5	$58,928,297.00	$57,545,734.81	$1,382,562.19
Stimulants, opioids, and cannabis	1	$517,155.00	$407,954.28	$109,200.72
Opioids and stimulants**	5	$33,912,631.00	$31,973,858.17	$1,938,772.83

Sexually Transmitted Diseases (STDs)	3	$782,690.00	$0.00	$782,690.00
Tobacco**	7	$4,774,182	$2,941,707.83	$1,832,474.17
Unspecified	1	$500,000.00	$12,762,193.24	$3,695,090.76

*For the PDMP program in the Office of Administration, targeted substances are Schedule II, III, and IV Controlled Substances.
**There are programs from the Department of Health and Senior Services under the "Opioids," Opioids and stimulants," "Opioids and Alcohol" and "Tobacco" categories that share the same appropriation that is not specifically divided among the different programs. The Missouri Department of Mental Health (DMH) is the state authority for coordinating a statewide response to substance use disorders. In addition to DMH, the Department of Health and Senior Services (DHSS), Department of Corrections (DOC), Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), Office of State Courts Administrator (OSCA), and Office of Administration (OA) all have programs supporting the prevention and treatment of substance use disorders in Missouri.

The Task Force again held hearings during the interim session. The Missouri state departments provided the bulk of the testimony. The cooperation of the departments throughout this process has been invaluable and exceptional.

Programs

The majority of programs related to SUDs are housed in DMH (Figure 3). In FY25, DHSS has the largest number of new programs (13) compared to DOC and OA, which have no new programs (Table 3). Overall, there were 25 new programs funded in FY25.

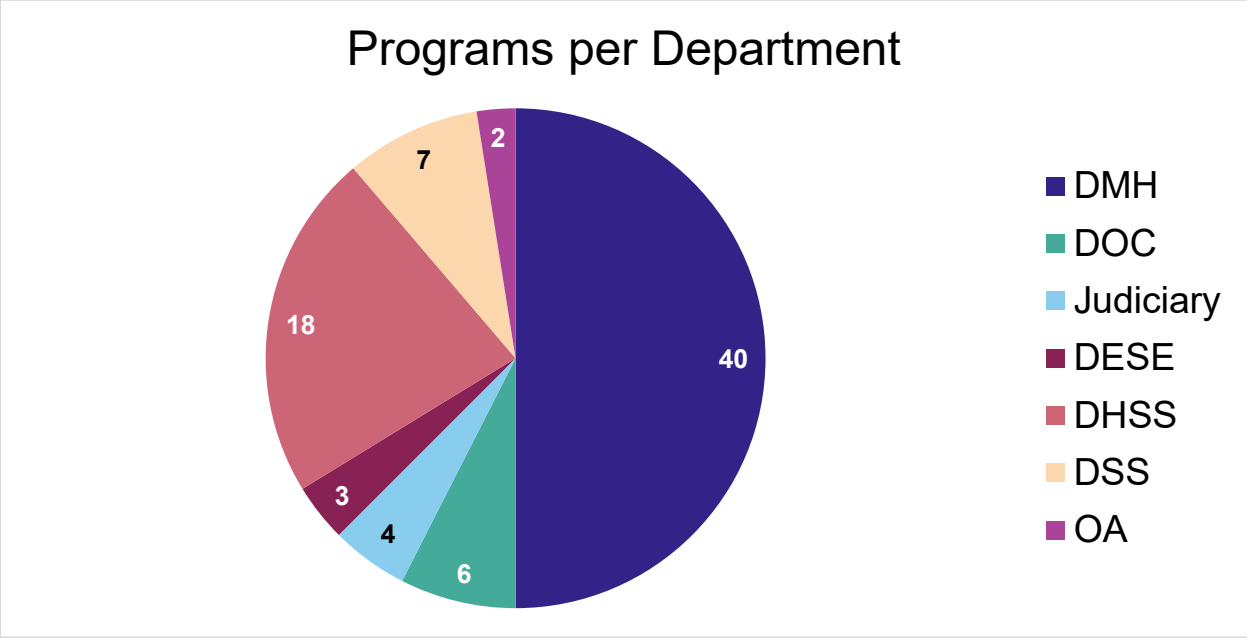

Figure 3. Total SUD programs in FY24 by department.

Newly initiated programs in FY25 are separately listed in Table 3; examples include capital improvement projects for substance use treatment facilities and wastewater testing and surveillance. Target substance data for new programs housed in DHSS was not provided.

Table 3. New SUD programs in FY 2025.

Program Name	Year Start	Department	Target Substance	Program Focus	FY25 Appropriations
Addiction Fellowships	2025	DMH	All substances	Treatment	$1,304,370.00
Adult Use - SUD Grants	2025	DHSS	Cannabis	Prevention, Treatment, Recovery	$5,848,619.00
Cannabis Prevention and Education Media Campaign	2025	DHSS	Cannabis	Prevention	$2,500,000.00
Capital Improvements (CI)	2025	DMH	Opioids	Administration	$636,000.00
Community and Youth Behavioral Health Liaisons	2025	DMH	All substances	Prevention	$500,000.00
Comprehensive Care for Women	2025	DHSS	Opioids	Treatment	$4,322,097.00
Disease Intervention Specialists	2025	DHSS	STDs	Prevention	$196,356.00
Fentanyl Test Strips	2025	DHSS	Opioids	Prevention	$216,300.00
Graduate Medical Education (GME) Program	2025	DHSS	All substances	Prevention, Treatment	$4,512,500.00
Hepatitis C Testing	2025	DHSS	STDs	Prevention, Treatment	$297,584.00
Housing Liaisons	2025	DMH	All substances	Treatment	$1,000,000.00
Naloxone	2025	DSS	Opioids	Treatment	$1,191,377.00
Peer Respite Services	2025	DMH	All substances	Recovery	$1,500,000.00
Peer to Peer	2025	DMH	All substances	Recovery	$100,000.00
Psilocybin	2025	DMH	Opioids	missing	$5,000,000.00
Rapid Hepatitis C Testing	2025	DHSS	STDs	Prevention	$288,750.00
Recovery Community Centers (RCC)	2025	DMH	All substances	Recovery	$1,200,000.00
Recovery High Schools	2025	DMH	All substances	Treatment	$10,434,783.00
Drug Abuse Resistance Education	2025	DESE	All substances	Prevention	$350,000.00
Youth Substance Use Prevention	2025	DMH	All substances	missing	$150,000.00

Medically Assisted Treatment	2025	Judiciary	Opioids, Alcohol	Treatment	$250,000.00
SUD Prevention and Education*	2025	DMH	All substances	Prevention	$150,000.00
Wastewater Testing and Surveillance	2025	DHSS	Opioids	Prevention, Treatment	$2,000,000.00
Alcohol Misuse Prevention	2025	DMH	Alcohol	Prevention	$500,000.00
Youth Tobacco Use Prevention Services	2025	DHSS	Tobacco	Prevention	$300,000.00

*SUD Prevention and Education may be a duplicate of Youth Substance Use Prevention.

Prevention vs. Treatment

Programs may have specific focuses with respect to substances targeted. They also have specific focuses on the type of services offered, including whether these focus on prevention, treatment, recovery, and/or harm reduction, or are used for administration costs. In FY25, as with FY24, the greatest amount was appropriated to programs that only focused on treatment (Table 4**,** Figure 4). This is also where the majority of FY24 funds were spent.

The largest number of programs focused on prevention only, and constituted the second highest spend for FY24. However, this was almost $200 million less than treatment programs.

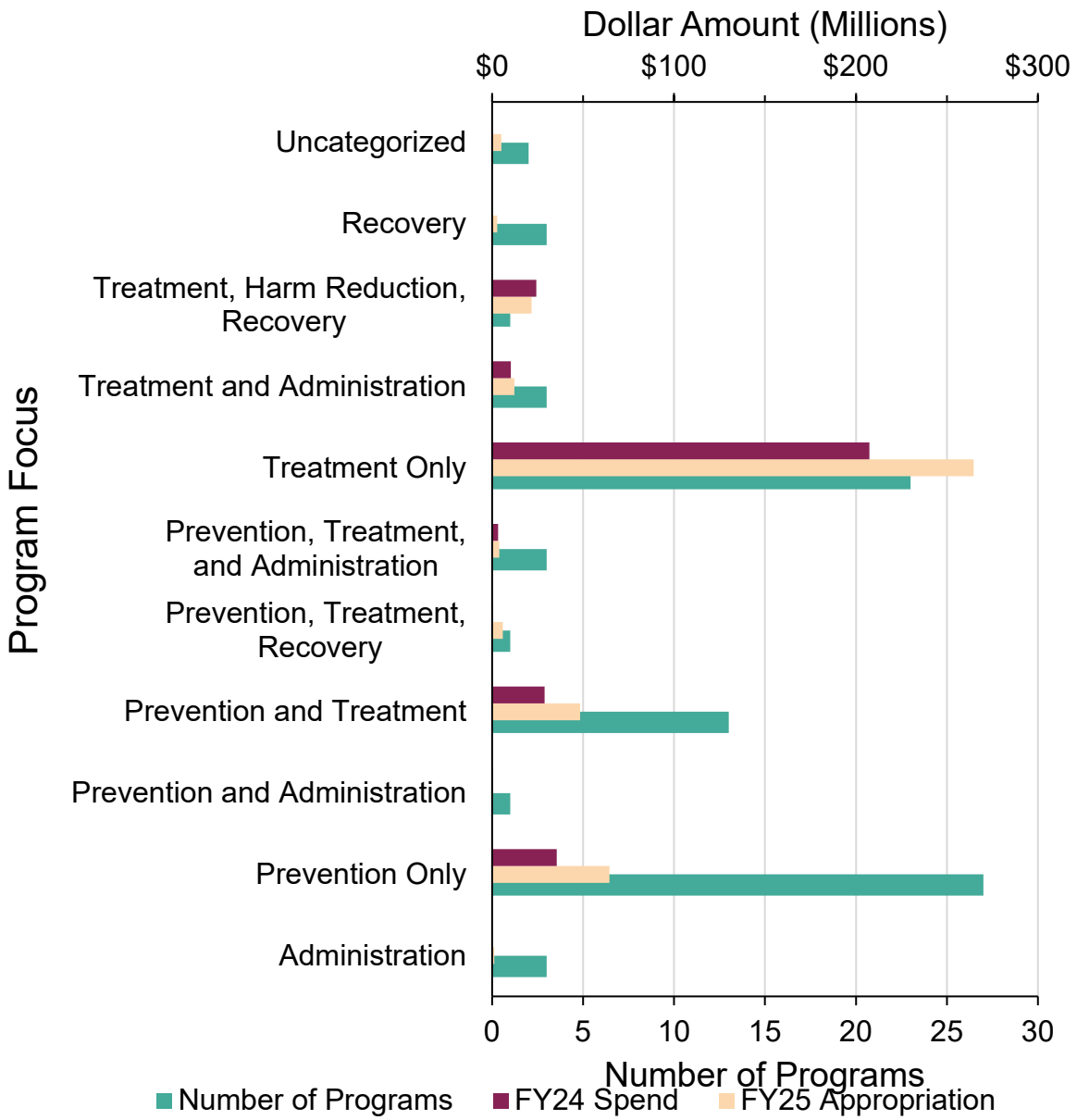

Figure 4. Amount spent on program priorities (prevention, treatment, etc.).

Table 4. Amount spent on program priorities (prevention, treatment, etc.).

Program Focus	Number of Programs	FY25 Appropriation	FY24 Spend	Additional Amount Appropriated
Administration	3	$1,184,515.00	$0.00	$1,184,515.00
Prevention Only*	27	$64,429,939.00	$35,473,686.13	$28,956,252.87
Prevention and Administration	1	$555,893.00	$266,133.00	$289,760.00
Prevention and Treatment*	13	$48,439,041.00	$28,794,065.56	$19,644,975.44

Prevention, Treatment, Recovery	1	$5,848,619.00	$328,638.00	$5,519,981.00
Prevention, Treatment, and Administration	3	$3,998,255.00	$3,226,610.00	$771,645.00
Treatment Only	23	$264,692,420.00	$207,315,356.81	$57,377,063.19
Treatment and Administration	3	$12,211,531.00	$10,222,171.24	$1,989,359.76
Treatment, Harm Reduction, Recovery	1	$21,626,445.00	$24,312,060.00	-$2,685,615.00
Recovery	3	$2,800,000.00	$0.00	$2,800,000.00
Uncategorized	2	$5,150,000.00	$0.00	$5,150,000.00
Total	80	$430,936,658.00	$309,398,720.74	$120,997,937

* There are programs from the Department of Health and Senior Services under the "Prevention Only" and "Prevention and Treatment" categories that share the same appropriation that is not specifically divided among the different programs. Therefore, these appropriations amounts are counted multiple times across this table.

The types of programs vary across departments. DMH houses the greatest number of total programs, and the majority of most program focus types (prevention, treatment, recovery etc.) (Figure 5). DMH includes most programs focused on treatment only, with the second most housed within the DSS. DMH also houses the majority of programs focused on prevention only, with DHSS housing most of the remaining prevention programs.

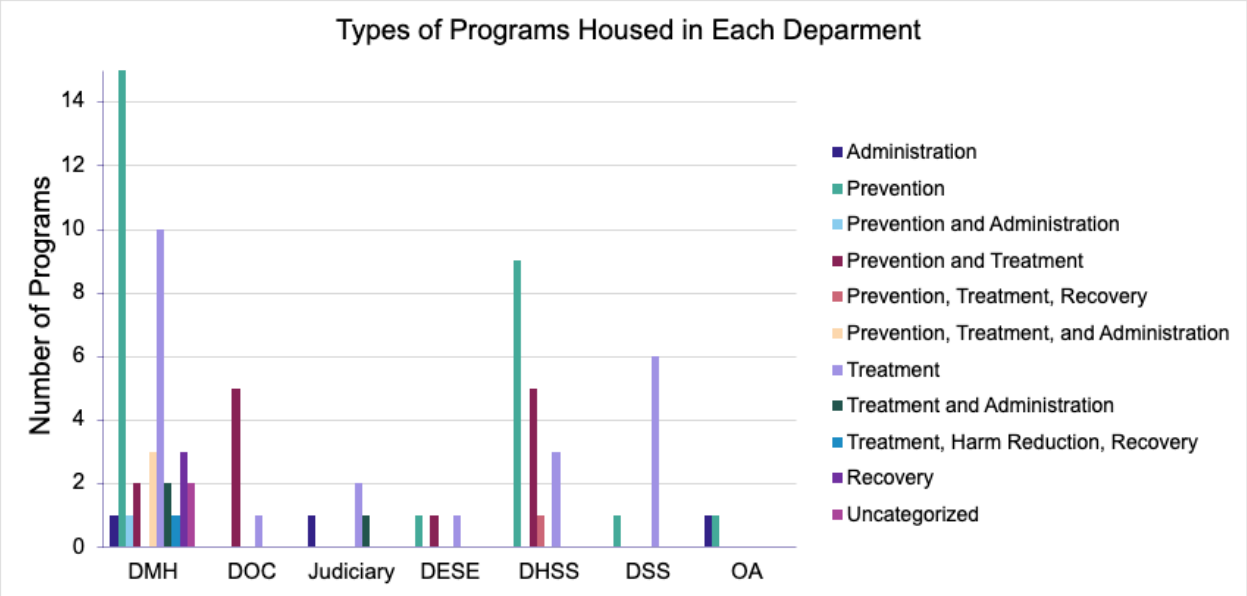

Figure 5. The focus of SUD programs housed in each department.

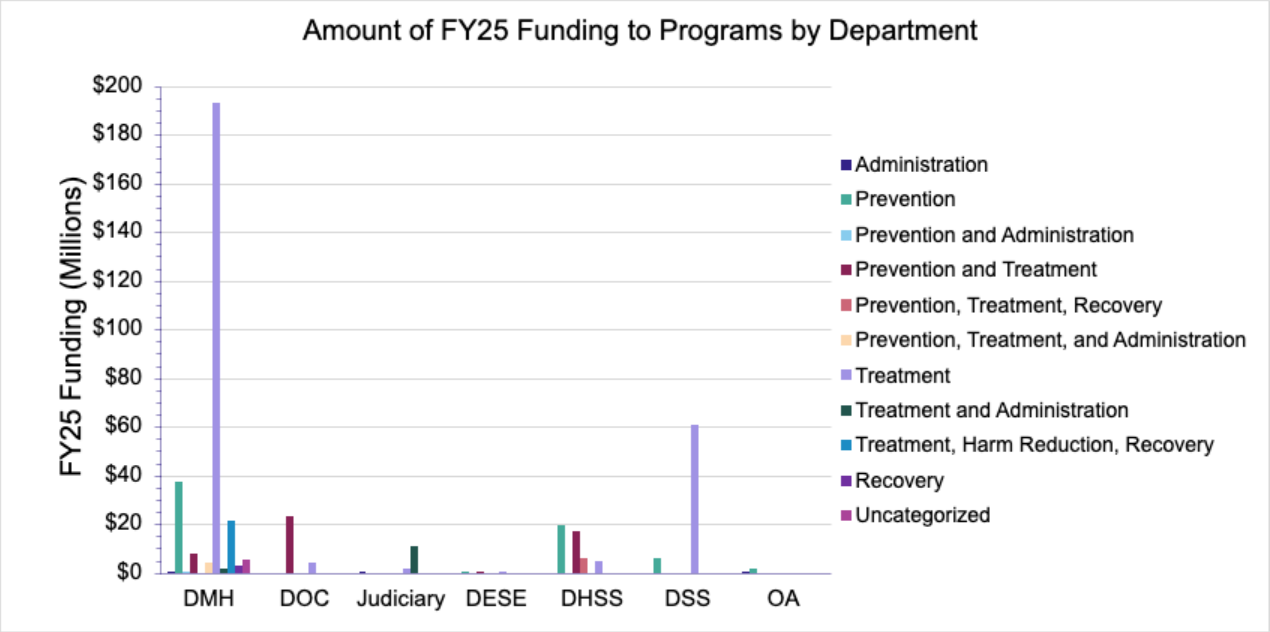

Figure 6. FY 24 appropriation for SUD programs by program service focus and department.

BUDGET OVERVIEW

Fiscal Year 2025 (FY24) appropriations for substance use disorders were calculated to be approximately $430 million, an increase from FY24 spending of approximately $308 million (Figure 7). This number is based on attempting to track all expenditures and appropriations and is thus approximate. The increase is reflected in new focus programs, increased funding for demonstrated effective programs, ultimately resulting in more people being helped. Some of the funding was one – time, and the ability to find funding to pick – up this appropriation will be critical to maintaining the improvement. (Figure 8).

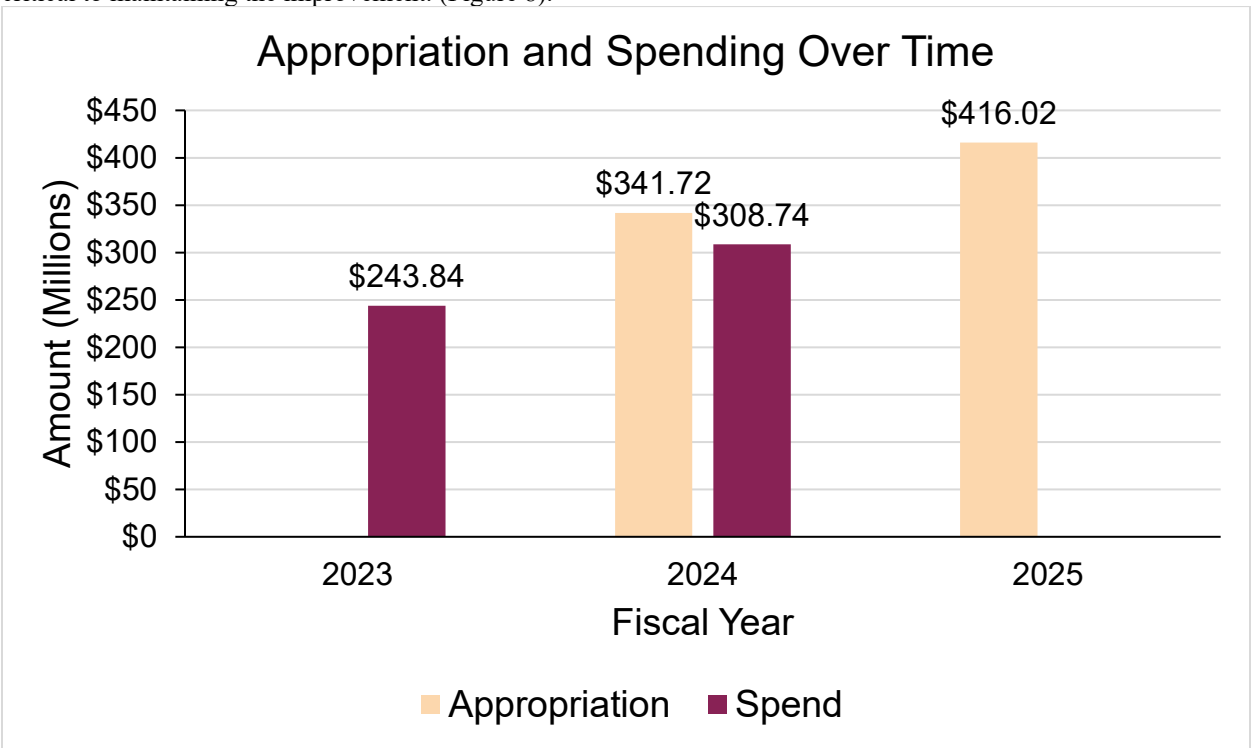

Figure 7. Appropriations and spending for SUD programs over time.

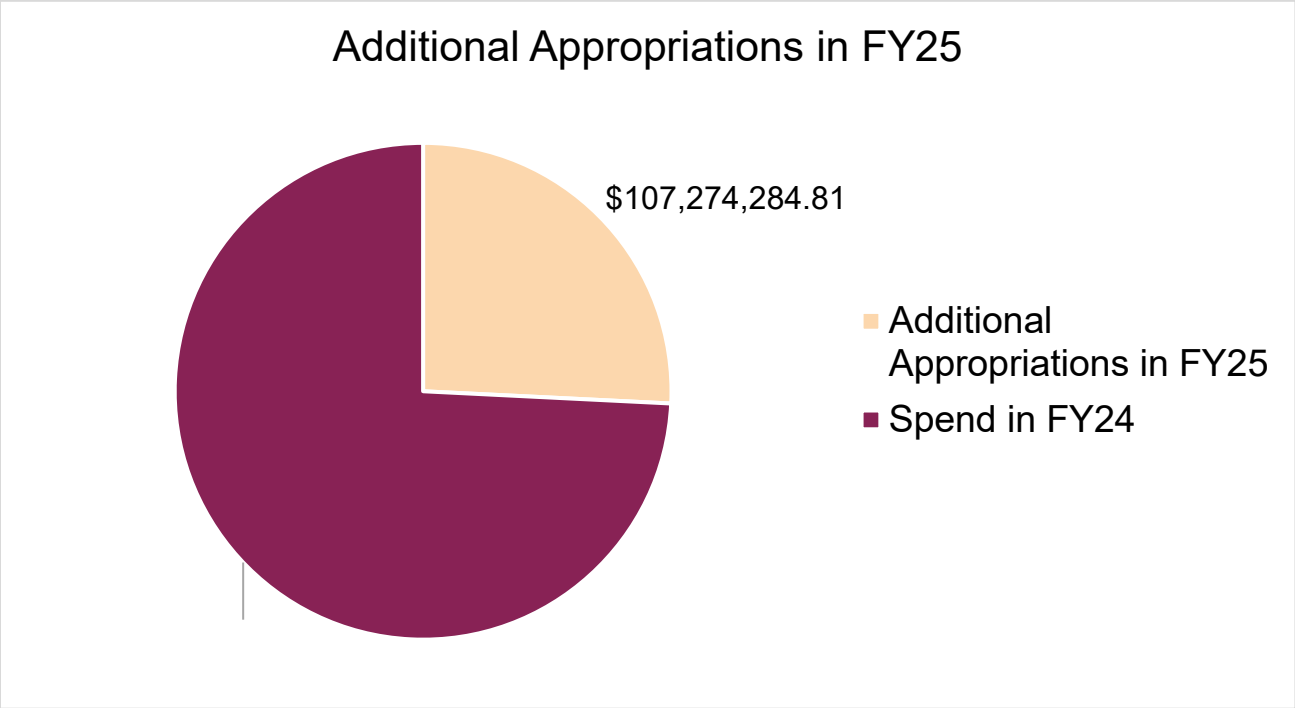

Figure 8. Additional monies appropriated in FY 25.

In FY24, DMH spent 65% of the total funds allocated for SUDs, and administered the majority of programs relating to SUDs (Figure 9). Again, it contained the largest number of programs devoted to SUDs (Figure 10). Similarly, DESE spent $604 on SUDs in FY24, despite being appropriated $1.2 million in FY24 (Table 5).

Some departments are receiving fewer dollars in the FY25 budget than they did in the FY24 budget (Table 5**,** Figure 10). However, all departments are receiving more monies in the FY25 budget than they spent in FY24 (Figure 11).

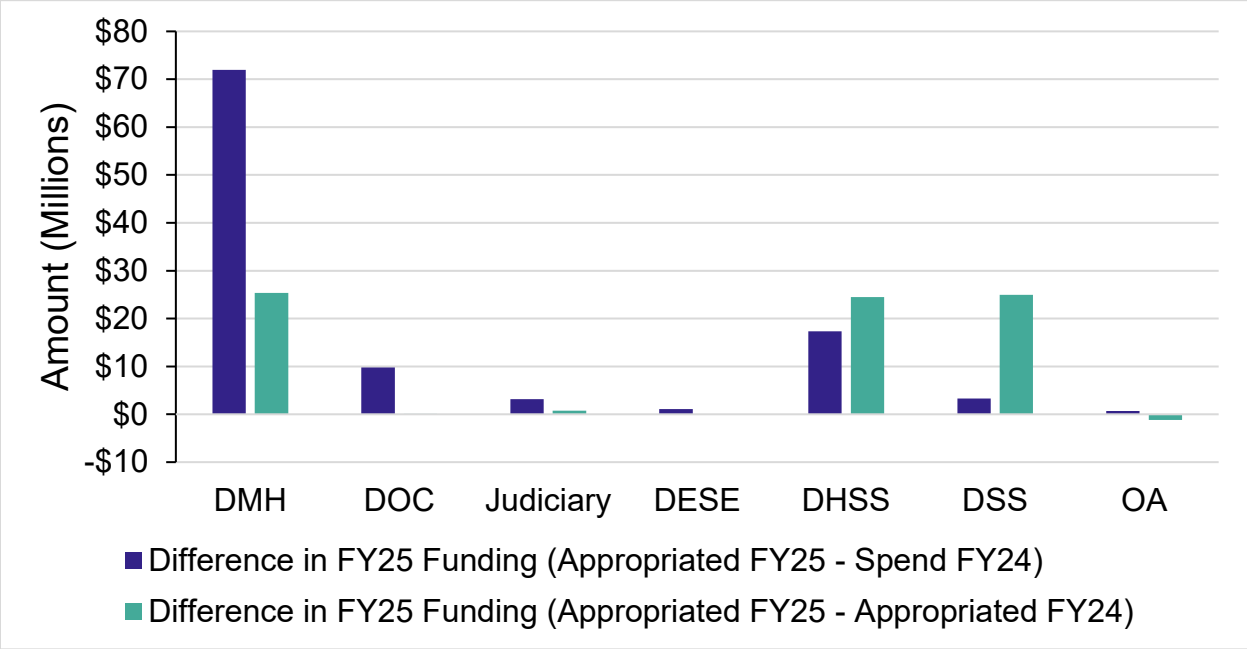

Figure 11

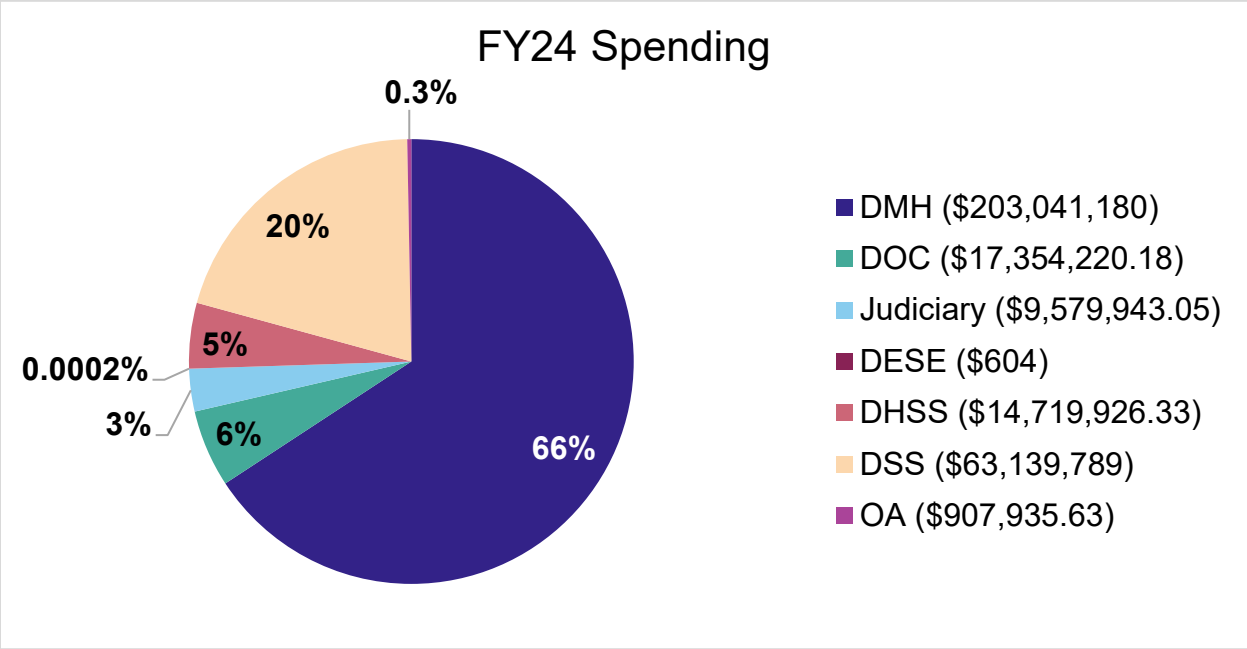

Figure 9. The percentage of FY24 spending on substance use disorders across departments.

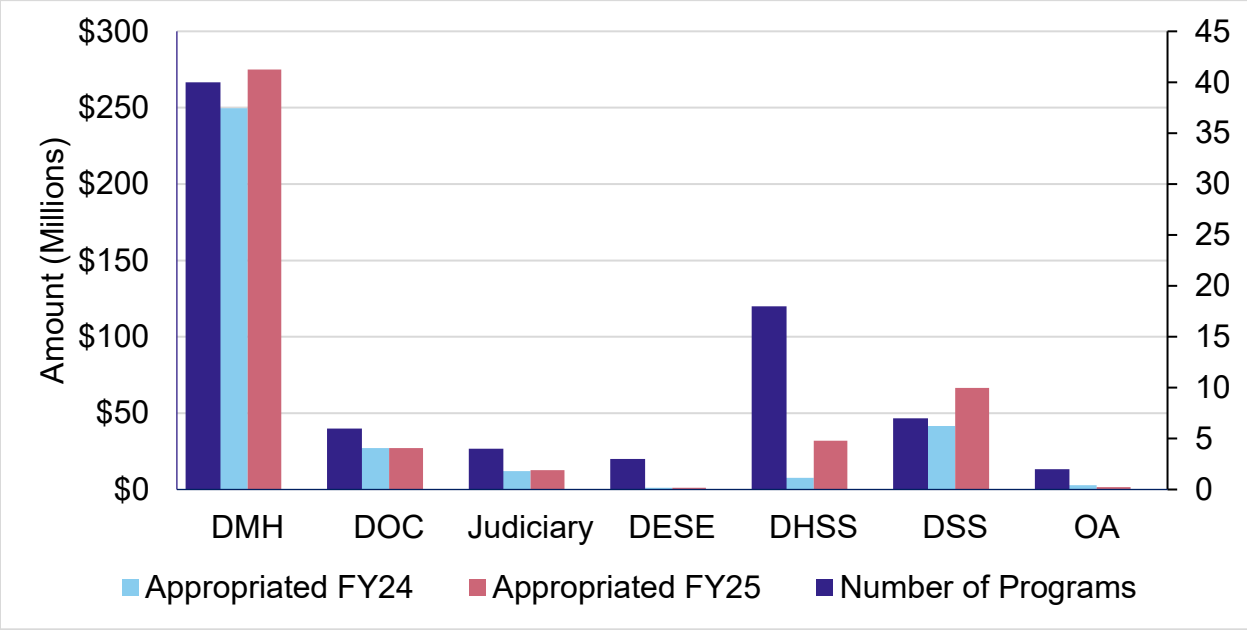

Figure 10. The number of SUD programs in each department compared to the FY24 and FY25 appropriations to that department for SUD programs.

Table 5. FY24 spending and FY25 appropriation by department.

Department	Appropriated FY24	Percentage of SUD Appropriations FY24	Spent FY24	Percentage of SUD Spending FY24	Appropriated FY25	Percentage of SUD Appropriations FY25
DMH	$249,613,637.16	73%	$203,041,180	66%	$274,992,686	66%
DOC	$27,068,643	8%	$17,354,220.18	6%	$27,108,112	7%
Judiciary	$11,953,607	4%	$9,579,943.05	3%	$12,715,570	3%
DESE	$1,210,600	0.4%	$604	0.0002%	$1,105,600	0.27%
DHSS	$7,557,418	2%	$14,719,926.33	5%	$32,035,474	8%
DSS	$41,485,714.66	12%	$63,139,789	20%	$66,442,595	16%
OA	$2,832,523	1%	$907,935.63	.3%	$1,617,846	0.4%

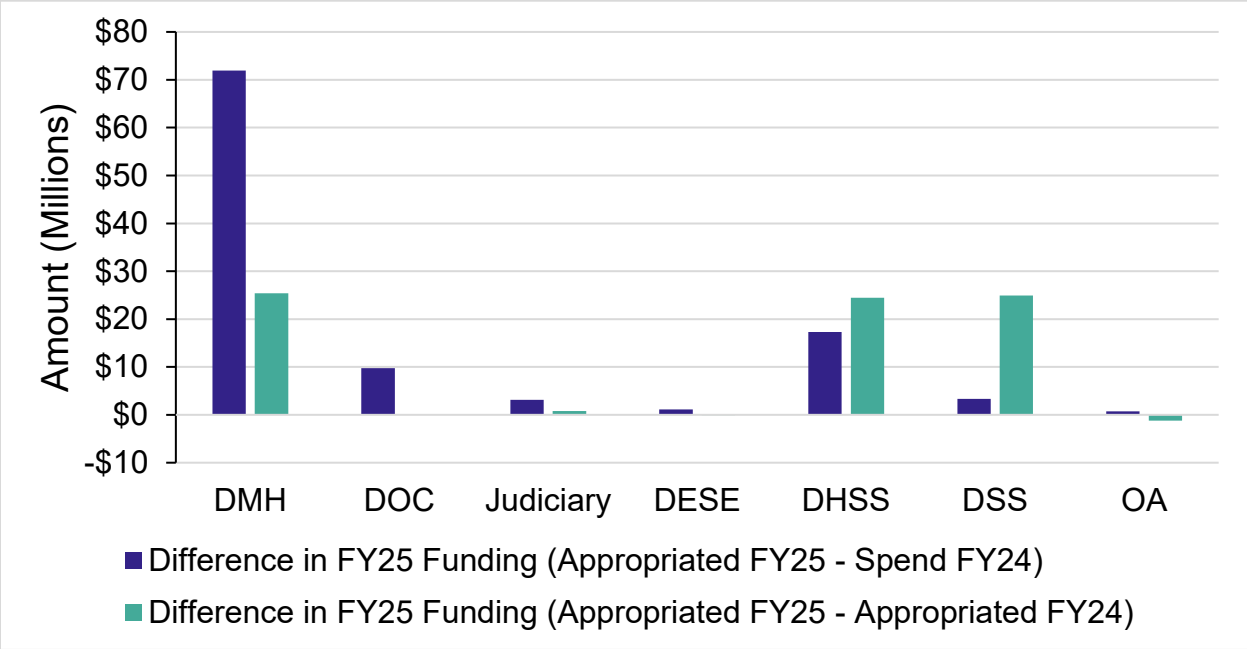

Figure 11. Appropriation and spend differences between FY24 and FY25 by department. The difference in funding for departments between FY24 and FY25 appropriations, and the difference between FY25 appropriations and FY24 spending.

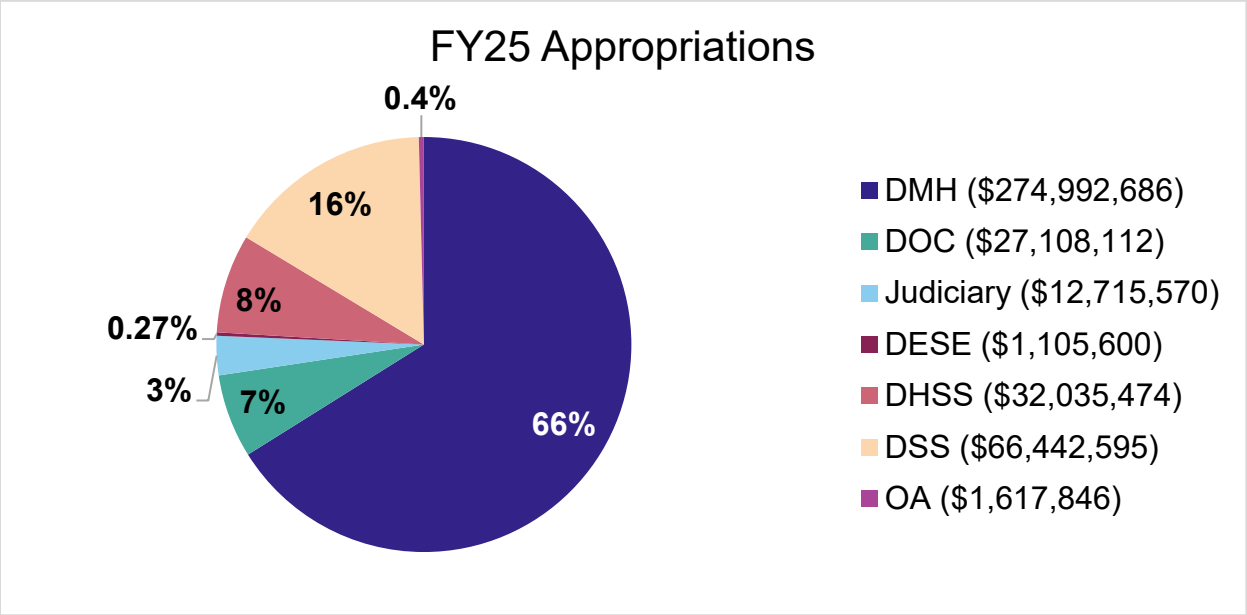

Figure 12. The percentage of FY25 appropriations for substance use disorders across departments.

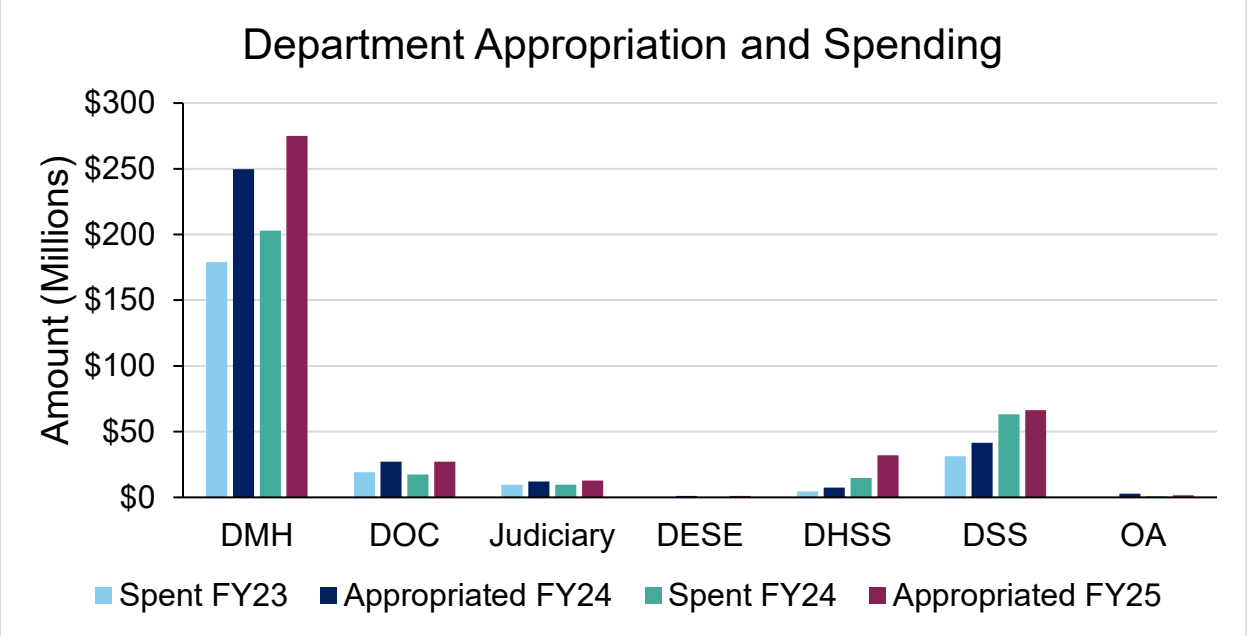

Figure 13. Appropriation and spending differences across Missouri state departments containing programs related to substance use disorders.

Table 6). Compared to FY24 spending, the FY25 budget contains an additional $122 million for SUD programs. This is a similar increase to the previous year, where $106 million was appropriated for FY24 compared to FY23 spending.

Of this additional funding, the majority ($70 million) was allocated to DMH (Table 6).

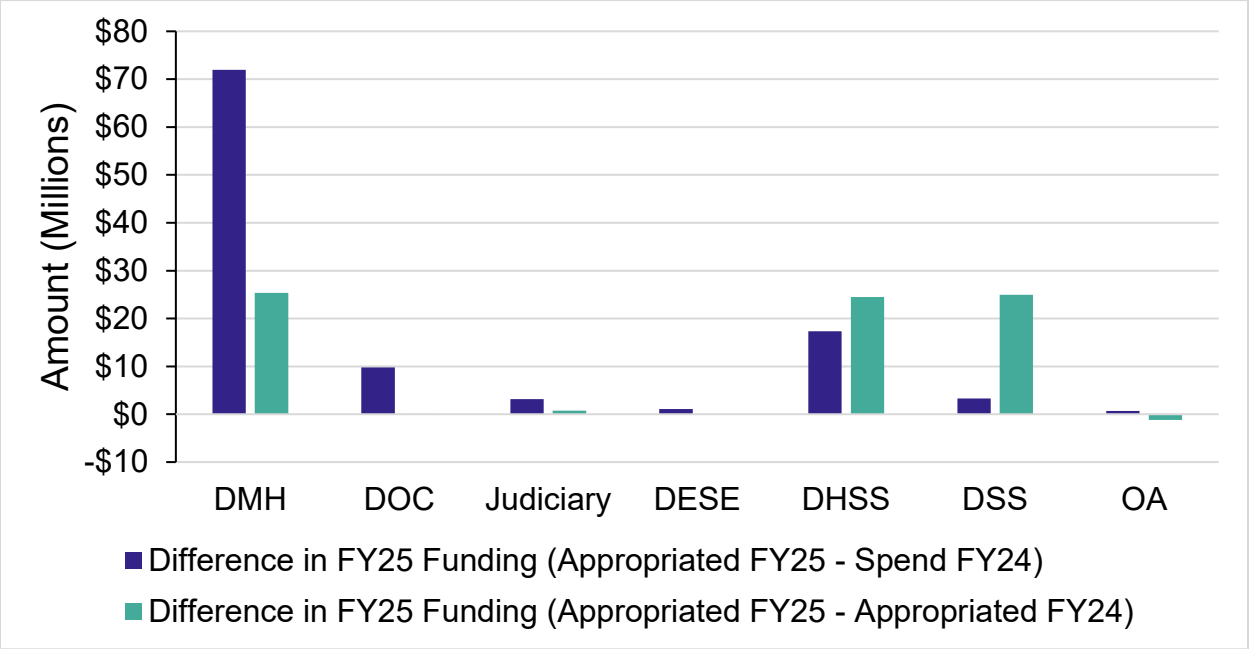

Figure 11, DHSS saw the next largest increase in funding, both when compared to FY24 spend and appropriations, and has added 13 new programs in 2025 (Table 5).

Table 7,

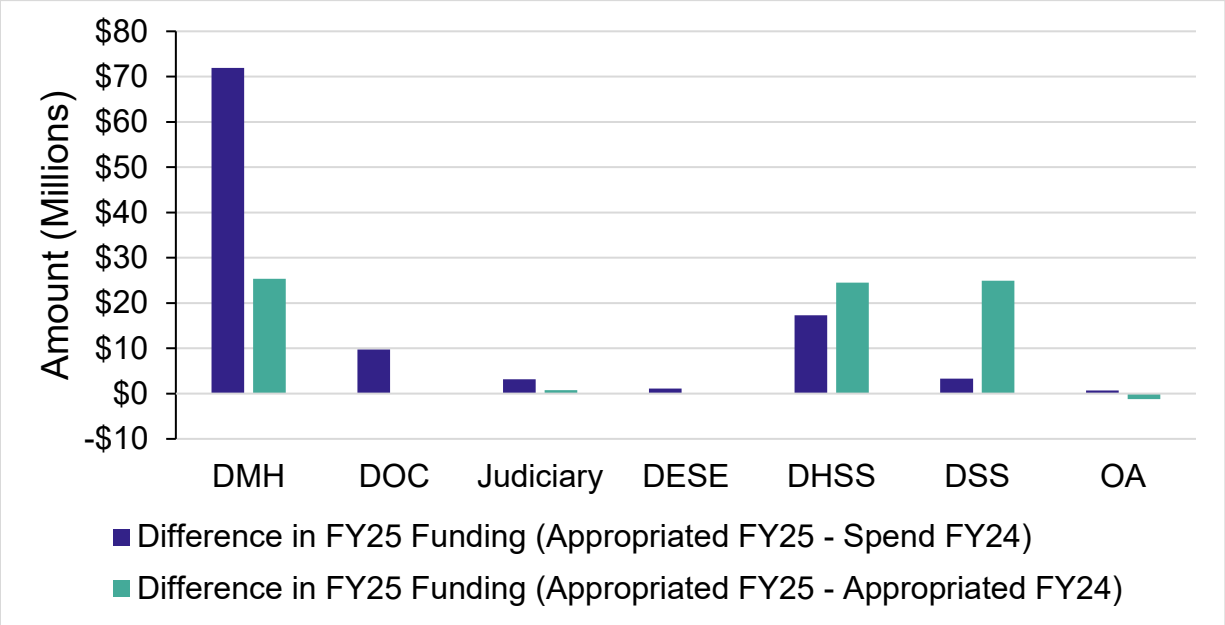

Figure 11

Table 6. Differences in appropriations and spending for FY24 and FY25.

Department	Appropriated FY24	Spent FY24	Appropriated FY25	Difference in FY25 Appropriations and FY24 Spend	Difference in FY25 and FY24 Appropriations
DMH	$249,613,637.16	$203,041,180	$274.992.686	$71,951,506	$25,379,048.84
DOC	$27,068,643	$17,354,220.18	$27,108,112	$9,753,891.82	$39,469
Judiciary	$11,953,607	$9,579,943.05	$12,715,570	$3,135,626.95	$761,963
DESE	$1,210,600	$604	$1,105,600	$1,104,996	-$105,000
DHSS	$7,557,418	$14,719,926.33	$32,035,474	$17,615,547.67	$24,478,056
DSS	$41,485,714.66	$63,139,789	$66,442,595	$3,302,806	$24,956,880
OA	$2,832,523	$907,935.63	$1,617,846	$709,910.37	-$1,214,677
Total	$350,259,330.82	$309,259,930.82	$415,987,720.74	$106,049,162.26	$65,728,552.18

Table 7. Additional money appropriated to each department in FY25, the percentage of the additional appropriation, and the number of new programs in each department. The additional funds were determined by comparing the amount of money appropriated to each department in FY24 with the amount appropriated in FY25.

Department	FY25 Additional Funds	Percentage of Total FY25 Additional SUD Funding	Number of New Programs in FY25**
DMH	$25,379,048.84	34%	12
DOC	$39,469	.05%	0
Judiciary	$761,963	1%	1
DESE	-$105,000	-0.14%	1
DHSS	$24,478,056	33%	10
DSS	$24,956,880	34%	1
OA	-$1,214,677	-2%	0

Table 8. The FY 24 and FY 25 funding for SUD within the DSS budget. The Department of Social Services (DSS) includes the MO HealthNet (Medicaid) program. Funding for programs in other departments are generally contained in those department budgets, and Medicaid spending is then accessed for Medicaid eligible participants. DSS has provided some direct funding for SUD, the bulk within the pharmacy medication assisted treatment (MAT).

Program Name	Program Description	Prevention Treatment or Admin	Target Substance	FY25 Total Appropriated	FY24 Total Expended
Substance Abuse Prevention Network	Grant programs for FQHCs for a substance abuse prevention network	Prevention	Opioids	$5,700,000.00	$2,397,194.00
Medication Assisted Treatment - Drugs	Payments for pharmaceutical assistance for substance abuse treatment	Treatment	Opioids, Alcohol	$25,131,149.00	$25,131,149.00
Medication Assisted Treatment - Drugs Adult Expansion Group	Payments for pharmaceutical assistance for substance abuse treatment	Treatment	Opioids, Alcohol	$29,483,005.00	$29,483,005.00

Naloxone	Payments for Naloxone through the Medicaid pharmacy program	Treatment	Opioids	$1,191,377.00	$1,191,377.00
Naloxone - Adult Expansion Group	Payments for Naloxone through the Medicaid pharmacy program	Treatment	Opioids	$882,913.00	$882,913.00
Treatment for Therapy (Family/Group/ Individual)	Reimbursement for therapy treatment related to a SUD diagnosis	Treatment	All substances	$2,684,677.00	$2,684,677.00
Assessment/Testing/Screening/Referral for SUD treatment	Reimbursement for testing/screening for individuals with a potential SUD diagnosis	Treatment	All substances	$1,369,474.00	$1,369,474.00

NOTE

MOST Policy Initiative is a 501(c) (3) non-profit, nonpartisan organization working to connect science to policy at the state level in Missouri. Members of MOST Policy Initiative were involved with data collection, figures and table creation, report formatting, and editing. Members of MOST Policy Initiative did not contribute to any interpretations or recommendations made from the data.

SUMMARY OF TESTIMONY

I. Hearing on June 24, 2024

Persons Testifying: Valerie Huhn, Angeline Stanislaus, Department of Mental Health; Todd Richardson, Josh Moore, Missouri HealthNet, Department of Social Services

Valerie Huhn, Director of the Department of Mental Health, and Dr. Angeline Stanislaus, Chief Medical Director, focused on the biology of addiction and the three main substances responsible for addiction.

Neurobiology of addiction – any substance can be addictive, if it causes tolerance, withdrawal, craving, and a sense of loss of control.

Genetics, a person's gender, and his or her experience relating to mental disorders, or a family history thereof, can impact whether a person is predisposed to substance use disorder, in combination with environmental factors: a chaotic home filled with abuse, a parent's use and attitude toward substances, peer influences, and community attitudes toward substances may play a role. It also depends on the route of administration of the substance being consumed, the effect of that substance, the initiation of use, as well as cost and availability of a substance. Each of these may change the brain's chemistry and what is being communicated via neurotransmitters.

Some drugs target the pleasure center of the brain, the dopamine pathways. These brain circuits are important for natural rewards such as food, music, and sex. Dopamine increases in response to these natural rewards.

The presentation focused on three main substances causing addiction: alcohol; opioids, particularly fentanyl; and methamphetamine.

Alcohol

Over time, the excess amount of dopamine released when consuming alcohol begins to impact a person's baseline dopamine level as well as reducing the natural production of dopamine, which can lead to symptoms of withdrawal. The timeline of withdrawal begins with symptoms such as anxiety, insomnia, nausea, or abdominal pain within the first eight hours, followed by high blood pressure and increased body temperature in the second stage, occurring one to three days from the person's last drink. The third stage, usually a week after the final drink, may feature symptoms such as hallucinations, fevers, seizures, and agitation.

There are three types of FDA-approved medications for alcohol use disorder:

1) Antabuse, which blocks the metabolism of alcohol, thus making the person sick if he or she drinks;
2) Naltrexone (common trade name: vivitrol), which blocks the opioid receptors, thus preventing the experience of a buzz and decreasing a person's craving; and
3) Acamprosate, which promotes the balance between the neurotransmitters, GABA, and glutamate.

Opioids, including Fentanyl

Fentanyl now comprises the vast majority of drug overdoses in the United States and has done so since 2018, due to its potency being between thirty to fifty times greater than that of heroin and one hundred times more potent than morphine. As fentanyl is a synthetic opioid that is grown in a lab, it is much cheaper to produce than heroin, less cumbersome to transport, and requires less product than other opioids, resulting in its widespread presence in the United States; this is exacerbated by its mixture into or combined usage with other substances, such as heroin, cocaine, or methamphetamine, which can make determining the amount of fentanyl present and whether it is a lethal dosage difficult. Fentanyl produces effects by activating μ-opioid receptors.

The timeline for withdrawal of fentanyl is similar to that of alcohol; the first stage typically begins between six and twelve hours after last using and can present as a range of physical and psychological symptoms including anxiety, depression, increased cravings, fatigue, difficulty concentrating, insomnia, nausea, vomiting, sweating, insomnia, diarrhea, cramps, and muscle aches or pains. The timeline of withdrawal may depend on the length of fentanyl use and a person's tolerance.

Medication-assisted treatment for fentanyl use, and opioid use disorder more broadly, is conducted using one of three medications:

1) Methadone is a full opioid agonist that reduces cravings for opioids and prevents withdrawal symptoms. While this medication may be introduced during the detoxification stage of a person's recovery, it is best used as a long-term approach to treating fentanyl addiction. Typically, this medication is recommended to individuals who have previously been treated for opioid addiction and were unsuccessful in sobriety;
2) Buprenorphine (common trade name: Subutex) is a partial opioid agonist, meaning that it binds to and *partially* activates opioid receptors without producing a high. It can prevent a person from relapsing by reducing the intensity of his or her drug cravings and withdrawal symptoms; and
3) Naltrexone is a full opioid antagonist that blocks the opioid receptors, thereby preventing the effects and reducing the craving. (Suboxone is a common trade name for a combination of buprenorphine and naltrexone).

Methamphetamine

Using methamphetamine produces an intense release of dopamine, serotonin, and norepinephrine into the brain's synapses, and is typically used recreationally for its effects as a euphoriant and stimulant, as well as its aphrodisiac qualities. Use of the drug was found to be related to higher incidents of unprotected sexual intercourse in both HIV-positive and partners with unknown status. This, alongside the practice of sharing needles to inject drugs, has

contributed to a heightened risk of HIV transmission among gay and bisexual men who use methamphetamine as well as for non-gay users.

Unlike for alcohol and opioids, there is no FDA-approved medication-assisted treatment for methamphetamine use, but non-medication treatments that have demonstrated efficacy include behavioral therapies, peer support and counseling, and what is known as "contingency management," which rewards people for staying drug-free with vouchers, cash, gift cards, or other small rewards.

Todd Richardson, Director of MO HealthNet Division, DSS, and Josh Moore, Director of Pharmacy for MO HealthNet.

MO HealthNet provides: 300 Medically Assisted medications, services through the Department of Mental Health. Managing 300 different classes of medications. To ensure good access to medication and appropriate controls; Focusing on medications covered for MAT.

Features: Open-access policy, meaning no prior authorization required to be completed by the physician or pharmacy for MAT; No copay; No limitation on how long a patient can be on these treatments, either. Some state Medicaid programs continue that; we don't think appropriate. Meeting participants where they are is important; if a diabetic took a donut, we wouldn't deny them insulin. SUD treatments are provided through Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs with state funding provided through the Medicaid program in the Department of Mental Health budget. Services include detoxification hospitals, screening and referral to primary care health homes, diagnostic assessment and counseling/psychotherapy by licensed behavioral health professionals along with care coordination and management directly to MO HealthNet members.

Substance use disorder and opioid use disorder. In FY 2024, 72,666 participants received at least one dosage of substance use treating medications, resulting in total reimbursement of $54.6 million. Some participants have multiple SUDs, some are on Medicaid expansion, or are a part of another eligibility, which could lead to double-counting – this has been de-duplicated by the Department so as to not skew data. All policies are statewide; MO HealthNet Pharmacy doesn't do managed care, and the Department encourages utilization for treatment options that are available.

Broad access – a network of CCBHCs, FQHCs, and new funding to improve access. Director Richardson testified there is room for improvement, as well as having the sufficient network of providers who are able to treat patients. Some areas, in rural areas especially, it is more difficult to attract providers.

In FY 2024, MO HealthNet paid at least one claim for select OUD treatments for 14,580 patients, which came to a reimbursement of $33.9 million, all pre-pharmaceutical rebate. Generally, 55-65% of what the state spends comes back in rebate (note: testimony and budget figures are sometimes difficult to reconcile as a result). Includes buprenorphine, naltrexone tablets and injectables. Some people have OUD and AUD, and vivitrol works for both, so it is difficult to determine which they're using for, or both.

Last year, the division carved buprenorphine injectables out of the inpatient per diem, so hospitals are separately reimbursed for giving a patient an injection before they leave the hospital. This is a result of thinking about pregnant moms who just delivered, who may be dealing with the requirements of OUD treatment, and how that could be quite overwhelming.

Alcohol use disorder. Alcohol use disorder is very undertreated in MO; out of over 1 million participants in MO HealthNet, it's impossible to fathom only 7,600 having such a disorder, (see by contrast the testimony at the hearings on June 24 and September 16, describing the billions of dollars societal cost to alcohol addiction) and the Division spent $1.4 million last year. To try and address this low uptake, DMH sent out a provider blast in May, highlighting the coverage of these products, the undertreatment, and will be periodically reminding physicians and nurse practitioners, reporting facts of 8200 alcohol related ER visits, 1900 deaths, and other information regarding alcohol use disorder. A lot of people don't think of AUD as a disorder, and its use is widespread and socially acceptable.

Tobacco use disorder. Tobacco Use Disorder has the highest volume: 58,000 participants received treatment for a total of $8.8 million spent on nicotine replacement (all forms) and reimbursed for pharmacists prescribing nicotine replacement products. Some claims come through from those, as well as NPs and physicians. (Again, compared to the cost in billions reported in other testimony).

Naloxone. Since 2001, MO HealthNet has provided Naloxone rescue agent in appropriate circumstances. In FY 2024, the cost was over $2 million for approximately 23,000 participants.

DisposRX. Only Medicaid program in the nation that covers DisposRX packets to allow safe disposal of medication at home. 2024 fiscal year and 5500 participants, at a cost of approximately $139,000.

No pharmacy benefit manager. MO HealthNet does not utilize a PBM – there are vendors that help support claims being paid and request reviews, and there are multiple meetings per week. Prices paid to pharmacies are set on national benchmarks, and that data is available publicly and online.

II. Hearing on July 25, 2024

Persons Testifying: Nora Bock, Valerie Huhn, Department of Mental Health; Trever Foley, Annie Harmon, Department of Corrections

Human and Economic Costs. The Department Mental Health reports that 943,000 Missourians suffered from substance use disorder in the past year, 531,000 from another drug use disorder, and 536,000 Missourians with alcohol use disorder. The Missouri economic cost of alcohol and drug use disorders is estimated at approximately $4.5 billion for alcohol, and $4 billion for drug use disorder, a total of approximately $8.5 billion.

Drug czar. One of the questions sent from the Task Force was about a "Drug Czar," and whether that could be something that helps the state. Operating DMH like this, there are a lot of questions we have around that. If a position is added, it should be meaningful, and not a barrier to progress. We're trying to understand what problems the Task Force are trying to solve with a Czar. This person would coordinate efforts between departments, but that requires meaning as well and would likely need some sort of statutory change. There is a drug czar at the national level, which has evolved over the last 20 years. Further research would be needed. Indiana and Arkansas have them, but theirs is predominantly law-enforcement related.

Access. The supply of access does not meet the demand. A workforce shortage contributes. Access is critical to sustain improvement. It is important to diversify access points in recovery - What that means is that there are multiple touch points along the continuum, more avenues for prevention and public education messaging, plugging into the treatment system, or referral from DOC. Important to have as many opportunities as possible for those seeking recovery to maintain access to nonmedical but critical resources. Additionally, it is important to increase the number of programs and increase the statewide distribution, or saturation, of Naloxone.

Measuring success. Measuring success – DMH has monitoring mechanisms, is the regulatory authority from state and federal funds, and we do funding reviews. We also have fidelity teams, which, to an evidence-based practice, is being followed as closely to the model as possible. One measure of success is the decrease in 2024 in drug overdose deaths across the state. The distribution of Naloxone is undoubtedly a factor and will be required to continue this success. (The report of Dr. Rachel Winograd, task force member, on October 29, provides more detailed information). Our central office conducts those surveys, samplings of records and we assess the programs' fidelity. We can say if "X" provider has improved over the last year relating to fidelity. National benchmarks, departmental participation in federal surveys.

The substance use budget is in three buckets: prevention, treatment, and recovery. It is important to know that prevention and recovery support services are not billable to Medicaid and rely solely on state GR, federal block grants, and federal discretionary grants (note: and recently, opioid settlement and recreational marijuana tax.

Prevention. Medicaid, the most common source of payment, does not cover prevention, or recovery, only treatment. For the block grant, the Department is required to set aside 20% of that for prevention, and SAMHSA is overseeing this. They created a new office of recovery services, but Congress has not approved that. So, for a set of organizations

having access to $12 million, next year they'll be dropped significantly for a small budget. Prevention stays pretty steady, but that has also been supported through supplementary dollars, and what goes up must come down.

We do try to be a no-wrong-door system, so the more types of these programs, the greater the likelihood that we will find people, or people will find us. How do we make our services known? One of the easiest ways is to get in touch with DMH. We've made a variety of options available to call, text, email, hit the webpages.

988. Long-term support is vital to this program that is making a difference. We can talk a bit more about 988, as it isn't just for people experiencing suicidal thoughts, but it can provide more information on the types of resources needed.

You can call, chat, and text, and during FY24 we got over 95,000 phone calls, 15,000+ texts, and there were over 5,800 chats. We were talking about the success of our programs; nationally, MO is doing extremely well in in-state answer rate and time to answer. We feel good about our efforts in this space. We also have a way of tabulating impressions, which is how often an ad or material is seen. Billboards, things on websites: There were over 133 million impressions, and up to 27 million since May 2024. In terms of spreading the message, we're feeling good about that. Also available, DMH page phone line 1 800 575 – 7480 will connect with a real person to provide treatment programs and resources.

Crisis Diversion. Behavioral health crisis centers are relatively new and are providing the better understood necessity of rapid time to treatment as opposed to delay in providing services which frequently prevents treatment, at locations where people spend less than 24 hours. They can be brought in voluntarily or by law enforcement, 19 currently in place, 5 more coming soon. We served over 41,000 people in FY24 at these centers. Medication for OUD can often be initiated as well, with positive opportunities for someone in crisis to immediately begin receiving services. There are many localities who desperately need one, want one, but geographically speaking there are some serious challenges to getting to certain places of the state. Some were brought up through community investment. We do recommend an expansion of the locations for which these efforts have been initiated to implement additional behavioral health crisis centers.

Liaisons. We have talked for over a decade about liaisons. We have more than 80 Community Behavioral Health Liaisons throughout the state, who are effective connectors between DOC and the courts, and it is a diversion opportunity. If police or sheriffs know someone, they could be assisted in safely connecting persons to services. There are also 40 youth liaisons. In terms of referrals, in FY24 there were over 20,000 referrals made to adult services, and almost 6,000 referrals to youth-based liaisons. This is how we get people connected to the treatment system at large. They work in CCBHC and some CSTAR programs.

EPICC. EPICC specifically focused on the opioid crisis, focusing on overdoses. The model is that a peer with lived experience reaches out to someone after overdosing, and so we have them in multiple locations, 24/7 on call, and hospitals utilize them for anyone who comes in who, in their assessment, has SUD. The peer model is extremely effective as a first venture into the treatment world, because if you overdosed, you likely weren't headed to treatment that day. But it's a brand-new opportunity. (A similarly funded "Network" program is funded through the Department of Social Services is proving valuable in time to treatment – see testimony from September 26).

Mobile Crisis Response. Mobile Crisis Response is something our state has long done but was reinvigorated with 988. We had an existing system, transitioning to the 988 system so we have coverage, but in terms of requests, there were nearly 19,000 referrals. Let's say you call 988 and you cannot resolve your situation over the phone. If someone thinks an in-person connection is needed, or getting them access to resources is needed, or a face-to-face intervention is needed, they can send the Response unit. It can happen in hospitals, a park, or other public location. If they are dispatched to a home, they usually take someone with them, but this means a team is going out to the individual.

Crisis Intervention Team is a program we do with law enforcement. We want to equip LEOs to better understand mental health conditions, SUDs, what they might see, and how to effectively deescalate. Those officers are often dispatched on these calls, then handed off to a CCBHC. Almost 16,000 officers total have been trained, not sure how many are still in the workforce. Over 1,400 people trained last year.

CSTAR, CCBHCs. There are also a variety of SUD treatment providers, served by Certified Community Behavioral Health Clinics (CCBHCs) and Comprehensive Substance and Treatment Rehabilitation (CSTAR). That's where you can see a doctor, counselor, receive historical trauma services; it's a comprehensive and team-based approach. Most CCBHCs do have open access, meaning you can just walk in and see someone. Logistically not possible everywhere, but they've worked hard to be as accessible as they can. Many CSTAR programs utilize a low-barrier intervention called medication-first approach. The gold standard of care is to get OUD patients on medication first, meaning they don't have to wait weeks to get a prescription from a doctor.

All of our programs do some level of advertising. Fairs, social media, community events. Programs are good at having a local presence and being visible to their communities. A lot of school-based services as well, which allows for access after observing a child at school. Take them through whatever door they come through and try to offer services.

The CCBHC model treated over 218,000 people in 2023 and has enabled an increase in securing prescribers and getting trained on evidence-based practice. Increased use of medications by 285%. That 11,000 is primarily people with OUD, since that is what the medication approved by the FDA treats. Those receiving medication for their addiction is a tremendous help.

In Missouri, we have specialized CSTAR programs, for women and children, adolescents, opioid treatment, and general population., including 1700 adolescents. 4400 women, over 3600 in opioid treatment, and 26,000 in general population. (Rounded numbers). Medicaid only reimburses from CSTARs for treatment. At the highest level what we would provide is residential treatment with no date range for recovery.

Recovery Support Providers. Recovery support providers and the related recovery community centers provide a big bang for the buck. The Task Force got a lot of great information about recovery support providers last year, but we have organized in that there are 5 access sites, and the hub. So those in need of housing, transportation, care coordination, get vouchers from this hub and can go to providers. These providers can offer treatment if they have appropriate credentials, but this is a peer model, and this is where wraparound services come in. Transportation, for example, is a huge barrier. This is a gap-filler, and these providers do a good job of filling gaps, because not any one program can meet all needs. Over 2500 accredited recovery housing beds are provided in 120 men's homes and 100 women's homes.

Recovery Housing. These are also providers of temporary housing. Specifically, to recovery housing, we have over 2500 beds for recovery housing in the state, accredited by a national organization; there are 120 men's homes and 100 women's homes. HUD provides grants for rental and utility services for approximately 2000 households in the state. There's been a 66% increase in net applications for Social Security disability benefits, with over 80% of people applying reporting homeless housing status.

Peer Respite Crisis Stabilization initiative. In 2023, a peer respite crisis stabilization low barrier housing pilot program was relaunched – in one year, approximately 1400 individuals were served and over 3000 connected to services. Approximately 69% received discharge housing, with the majority from recovery support providers. Funding for the program does not meet demand.

Recovery Community Centers. Recovery community centers are new, too, and right now there are 12 across the state. Since 2018, more than 136,000 people have been served. Though not treatment centers, this is where folks can go and get mutual support, sober activities, receive peer support, employment preparation. They're also a major referral source, and a huge source for Naloxone. They distributed more than 14,000 overdose reversal kits just last year. And in FY23, 31,000 people accessed services here.

Prevention. Prevention as an access point: 14% of the overall budget for substance use services. This system is organized with 10 regional centers. What is important about this is that they are then connected to over 150 registered coalitions, which can be tiny, but are boots on the ground doing prevention work. They'll speak at courthouses or churches about drug use. They work with local coalitions for technical assistance, teaching evidence-based approaches to prevention, and connect people to the larger system. Through all of these activities, connections can be made and strengthened. Last year, over 372,000 individuals served, and also a college program, Partners in Prevention, serving over 200,000 college students last year. We do know that our most recent data shows that MO

students are having more trouble accessing substances and are reporting the dangers of substance use. However, the number of daily drinking students is increasing, marijuana use is steady, and a quarter of those who do use marijuana do so daily.

Challenges. Number one – transportation; Number two – housing services; Number three – jail services; Number four – crisis services. Contributing to all, crushing workforce shortages; Pick-up of one-time funding; complexity and time – It's hard to break down in 5-6 things the inherent challenges in treating those with SUD. You may have heard of SIM Mapping, happening in every county in the state since 2021, and it's a tool to identify points in the justice system where different interventions could happen, as well as to identify gaps in a given community where people fall through, getting them into the cycle of criminal prosecution. Participants rank their biggest challenges or identified priorities; the very largest is transportation, followed by housing services, then jail services, and then crisis services. Systemically, a challenge to people with mental illness or SUD, or both, transportation is a significant problem in accessing treatment. Housing is an incredible barrier. KC was the highest in the country of people unsheltered in the country who experience long-term mental illness. It cannot be overstated that there is a huge lack of affordable housing in MO, whether that's for low-income people or those with behavioral health challenges. There is a shrinking workforce, too, and while we've been successful in attracting a workforce due to the CCBHC model, we have a shortage of bodies coming down the pike.

Another challenge is that individuals have complex needs. We're not just dealing with an addiction to alcohol, for example. This is the safety net population; social problems, housing problems, legal problems, economic issues, none of which are easy to treat due to the complexity or combination of their situations.

We're hearing national reports of more young people in distress, exposed to more violence than prior generations, and the youth challenges are significant. There is also a challenge of one-time funding, but with a caveat: The department and programs will forever be grateful for any funds that help achieve their goals and provide services. There is not a steady stream of revenue for programs that need to be sustained year over year. Operating budgets need to be maintained or expanded. There are challenges to be able to expand the system, open it further.

Department of Corrections. Trevor Foley, Acting Director, and Annie Harmon, Director of Offender Rehabilitative Services.

Individualized Treatment and Recidivism. Missouri's programmatic changes to provide individualized substance abuse treatment have contributed to a drop in recidivism rates since 2008 from 44% to 30%. About 40% of all entrants are referred to substance services based on screeners, 15% of which entries indicated risk of OUD. Meth remains the most popular choice, but opioid use is rising. Just over 25% of the prison population requires psychotropic medication, and nearly 74% of these are estimated to have a co-occurring SUD. Outcomes in correctional settings tend to be very longitudinal, and it takes a while to provide good data; usually have to go to a release date from incarceration and then return to the community before being able to evaluate performances.

Range of Services. DOC offers a range of services. Moving to an effort of looking at individualized case plans. Number of criminogenic factors driving criminal activity, with SUD being one of those. Comprehensive wraparound care, based on an individualized assessment of a person's needs, allows us to target which elements of treatment shall be prioritized.

The biggest evaluation tool that we use to evaluate success is our recidivism rate, which has always been a real problem in comparing data across states. The Council of State Governments released a comprehensive reincarceration and recidivism study to compare rates across the country, and Missouri saw the fifth-largest drop to a 30% rate as of the most recent data. Much of that reduction in the rate has occurred because of the rewriting of the Criminal Code, the justice reinvestment initiative, and those generated cost-avoidances have allowed for the reallocation of funds toward services. With fewer people incarcerated, our annual requests for the costs of doing business, have freed up resources that can be reinvested in other ways.

Expanded Services. DOC has focused on expanding substance use treatment programs, ensuring those programs are evidence-based, individualized, and able to receive services in a timely manner. It has implemented an instrument that screens for substance use at diagnostics centers as soon as people become incarcerated. The Department, with treatment providers, has gone to a vendor-based model, resulting in all of treatment being provided consistently by

the provider Gateway. Their model focuses on individual needs, the use of peer support, continuing education, family and community resources, and aftercare following the completion of treatment. As soon as they're assigned, they do an individual assessment to ensure they are getting the needs of the offender met. Gateway also has a robust reentry team, meeting with offenders transitioning back into the community to ensure their treatment plans can be continued. Priorities are to ensure the timeliness of services and continuation of care. Historically, when an offender became incarcerated, they'd need to be court-ordered for treatment. With community providers and Gateway, if a resident has a need to get services, they can be referred to treatment as well. So, they can meet with a clinical team and do tests there, then get treatment ordered. This gives more people the opportunity to get their needs met by services. This was a programmatic change, not a statutory one.

Problem: complicated criminal sentencing. There is, to some extent, a resource issue. With fewer issues, if you're not incarcerating people, a lot of criticism from law enforcement comes from a lack of understanding of criminal sentencing. Missouri has some of the most complicated criminal sentencing laws in the country, and there is a misperception about the nature of a sentence and the length of time spent in prison. The outcome not being what's expected drives much of that concern. They don't understand how a criminal sentence translates to a portion of that sentence served on probation. Maybe we need "transparency in sentencing" rather than "truth in sentencing".

Reentry Services. A lot of offenders do transition out, so that's why DOC wants to ensure access to resources in communities as well. There are institutional treatment professionals at each of the facilities who will meet with offenders, have counseling sessions, group sessions, and meetings for referrals to treatment. The goal is to ensure the offenders with SUD or OUD are seen by a clinician, provided MAT, and are given access to those one-on-one treatment services. This has helped take that turn with SUD issues inside of the facilities. Offenders on 6 months or less, have a pre-release focus, but that's been expanded at the beginning of this month. Where there is a need, they can get prescribed MAT and then referred to the health provider or the institutional treatment provider for counseling.

With Gateway, if someone is provided MAT, they have that reentry team to connect them to resources and focus on their treatment plan. We also have regional behavioral health care specialists, working with probation and parole officers and community providers on behavioral health, substance use, and other kinds of needed programs.

The goal with reentry services is to remove as many barriers during incarceration and schedule as much support as needed prior to reentry into the community, participating in a nationwide initiative ensuring access to reentry services, good on collaboration with state and local agencies, and community partners. It is about partnership, and we as a department rely on state agencies to provide services from the Department of Higher Education and Workforce Development; their staff helps with work training, a platform called Career Edge for exploration, new assessments to see their skillsets, and that's the partnership we provide. DSS also helps with TANF and Medicaid applications before they are released so they're ready to transition. Not only are they getting enrolled in Medicaid, but also have a birth certificate, non-drivers' licenses ID cards, SSN cards. Everyone being released in the next five years will need a REAL ID. With all of this being said, substance use is a major part, because if there isn't a treatment plan, they won't be successful in their transition. So much relies on each other and is integral, going back to that collaborative effort in partnership.

Most of the national conversation, like Missouri, is focusing on individual care. There are a lot of programs and resources, more going to this than the corrections world has ever seen.

Biggest Problems. Transportation and housing remain the biggest challenges. Ideas the director has been hearing include DOC building, supplying, and operating housing (only TN has rolled it out). It's more than just housing, it's supportive housing, a supportive environment with source availability on site. The services we focus on inside of the facility is getting the offenders ready for employment upon release. We need vocational planning, employers willing to hire offenders with the right skillsets, and want to release people based on where employment can be achieved. But that's where these struggles come from, because they rely upon these for their success.

III. Hearing from August 28, 2024

Persons Testifying: Paula Nickelson, Ben Terrell, Heidi Miller, Valerie Howard, Sarah Ehrhard Reid, Department of Health and Senior Services; Annie Legonsky, Mary Fox, Missouri State Public Defender system; Eric D. Jennings, Missouri Supreme Court; Richard Morrisey, Office of States Courts Administrator

Director Paula Nickelson, Legislative Liaison Ben Terrell, Department of Health and Senior Services:

Unacceptable statistics describe the high cost of substance use Missourians and Missouri: 14,088 people have died from overdose since 2016, ranked #32 amongst all states for overdose death rates in 2022. Overdose is the leading cause of death for adults 18-44 in MO, and of the 1,948 deaths from overdose in 2023, 73% were contributed to opioids. In 2022, death rate was 9.1% higher than US rate of overdose deaths. Data from 2019-2021 about maternal mortality indicates about 28% of pregnancy related deaths have substance use disorder as a contributing factor. In 2022, 6275 nonfatal emergency room visits from drug overdoses were non-opioid, which was 60% of all drug overdose emergency room visits., 37% of which were self-harm. Why is this important? The burden of overdose impacts families, communities, and health care systems. All genders, age groups, and races are impacted. People are using drugs to help underlying issues with the rise of infectious diseases such as HIV and STIs.

Misunderstandings impact program effectiveness. Programs are often plagued by misunderstanding relating to increased drug use and crime rates. Syringe services programs are safe, effective, and do not lead to rising crime or drug use rates. They also provide various services including access to free sterile syringes, screening for infectious diseases, opioid overdose prevention education, and provide naloxone, as well as linkages to physical and mental healthcare. Reduce the spread of disease and overdose, providing care to people who might not typically be engaged in health care. Also assist to protect first responders and the public by providing safe disposal sites.

The Missouri State Standing Order for Naloxone was updated June 3, 2024, were standing order for an opioid antagonist, with appropriate protocols.

Cannabis use. The Task Force also recommended more investigation into cannabis use and its effect on public health. There is being developed public listening sessions to gather input from stakeholders, then will issue draft rules for public feedback. Gov. Parson's executive order 2410 relating to unregulated psychoactive cannabis products required DHSS to embargo and condemn any food containing unregulated psychoactive cannabis products. We're posting FAQs and a complaint portal is underway for reporting these problems. The Missouri Constitution prevents the General Assembly from regulating the amount of THC in marijuana products.

Timing of Care. In its follow-up testimony, the department identified a lack of access to services after hours. Of the 815 suspected overdose cases identified in August 2024, 498 occurred outside normal business hours. After-hours response is often conducted by first responders, and difficult and time-consuming tasks impact emergency interventions. Connections to emergency care need to be updated. Missouri does not have a statewide platform to provide an integrated approach between mobile apps for behavioral health care. The Kansas City health department is piloting such a program.

Transportation. In its Missouri Overdose Strategic Plan, DHSS received comments addressing better management of housing and transportation services. In its follow-up testimony, the department said it was aware of only two effectively provided transportation services – one of which is in west central Missouri and one in the St. Louis area. Additionally, the department was aware that Washington County had implemented a mobile integrated care model in partnership with an EMS agency and a federally qualified health center. Telehealth can be used to combat transportation issues including for substance use disorder treatment.

Valerie Howard, Chief of Bureau of Community Health and Wellness, and Sarah Ehrhard-Reid, Chief of the Office of Women's Health.

Prevention and Data Collection. Prevention trainer hampered by the fact that death investigations are decentralized in Missouri. Coroners and medical examiners do not report to a single entity for oversight. As result, programs responsible death investigations such as Intentional Drug Overdose Reporting System, and Pregnancy Associated

Mortality Review Program must connect individually to obtain records. The results are burdens to the individual coroners and medical examiners and can result in incomplete data.

CDC funding and Prevention. For overdose prevention and response, there are few funding sources, including from CDC. The purpose of CDC funding is to expand overdose surveillance and prevention efforts, tracking overdoses, emerging drug threats, and associated risk factors and enhance bio-surveillance and data linkage, as well as promoting evidence-based strategies aligned with rapid shifts in overdose trends and using culturally relevant interventions and ensure equitable delivery of prevention services.

Surveillance Activities:

- Infrastructure: improving overall capacity to surveil
- Morbidity: collect and disseminate timely data from ERs and hospitals
- Mortality: collect and disseminate timely data on unintentional and undetermined intent overdose deaths
- Bio-surveillance: conduct toxicology tests on samples for nonfatal overdoses

Infrastructure Activities:

- There is a significant amount of info and data on the website, based on region, fatal vs. nonfatal, neonatal considerations, naloxone distribution, and fact sheets for each one of these and county-level fact sheets as well, sharing data on overdoses.

Morbidity Activities:

- Patient Abstract System conducts surveillance for nonfatal overdoses using ER and inpatient data, then uses data to provide resources to areas and groups most in need.

Mortality Activities:

- Track fatal overdoses using the vital statistics death files, and work with county coroners and medical examiners to get toxicology reports (voluntary and incentivized).

Prevention Activities:

- PDMP: contracts with the MO Hospital Association to support clinician education and ER based linkage to substance use treatment and care, as well as supporting statewide PDMP efforts.
- Harm Reduction: contracts with LPHAs for local-level activities, offer Harm Reduction 101 training and technical assistance to anyone who is interested, education and awareness campaigns, and harm reduction navigation contract to help those most disproportionately impacted by overdose.
- Public Safety partnerships: overdose fatality review is a locally based, multidisciplinary process for understanding the risk factors and circumstances leading to fatal overdoses and identifying prevention opportunities.
- Community-based linkages to care: transportation initiative in collaboration with DMH.

MO Coordinating Overdose Response Partnership and Support (MO-CORPS):

- Work with first responders and public health agencies to reduce overdose deaths through the coordination of overdose response partnerships
- Evidence-informed training for first responders
- Prioritize the 20 highest need counties
- Linkages to care through community behavioral health liaisons and EPICC referrals

Vulnerability Assessments indicate:

- More vulnerable to opioid overdoses in 2022: Madison, New Madrid, Pemiscot, Scott, and Stoddard counties
- More vulnerable to bloodborne infections in 2022: Callaway, Greene, Laclede, Randolph, and Stone counties.
- Overlap: Benton, Buchanan, Butler, Crawford, Dent, Dunklin, Howell, Iron, Mississippi, Phelps, Ripley, St. Francois, St. Louis City, Taney, Texas, Washington, Wayne, and Wright counties.

- Significant increase in the SE part of the state, with 24 of 28 of the most vulnerable counties being in the southern part of the state. Resulting from social determinants of health where people live, work, and play. Jobs, access to services, education, transportation, loss of rural hospitals and health care facilities.

DESE

Provides support programs to prevent youth substance use through drug abuse resistance education materials and programming for school drug awareness, including cannabis initiatives for youth.

Missouri Supreme Court

Support programs focused on medication-assisted treatment for those with SUD relating to alcohol and opioid addiction through Treatment Courts Coordinating Commission agreements with drug courts, DWI courts, veteran's courts, mental health courts, and other treatment courts.

Tobacco Control and Prevention

- Cigarette smoking is the leading cause of preventable disease, disability, and death in the US
- Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined
- 11,000 Missourians die each year from smoking related illnesses
- 1,150 Missouri adults die each year from exposure to secondhand smoke
- Missouri spends $3.5 billion annually to treat smoking-related diseases and $7.1 billion on lost productivity
- Missouri ranks 7 in the country for the number of adults who smoke
- Missouri has the lowest tobacco tax in the country, ranked 51st, at $0.17 per pack of cigarettes (national average is $1.83 per pack, next lowest is Georgia at $0.36 per pack).
- Missouri's Medicaid has the best access to cessation services in the country, with access to all 7 evidence-based medications.

Best Practices Relating to Tobacco use: In its follow-up testimony, the department identified Smoke Free Air Laws in 28 states that do not allow smoking in public places, correlating to preventing tobacco use initiation and use, reduced secondhand smoke exposure, and prevalence of tobacco use and up to a 70% reduction is hospital heart attack admissions. Tobacco free school district policies have similar results.

Next to Rise Youth leadership program:

- 7 schools participating
- 140 students trained in tobacco and vaping prevention, public speaking, networking, and advocacy skills

Community Conversations:

- 110 youth and adults participated in listening sessions held in 6 sites throughout the state where they discussed teen vaping and strategies to end the epidemic

Behind the Haze – "Choose Not Worse"

- 59,787,551 impressions delivered

Behind the Haze "Off"

- 49,591,356 impressions delivered

222 K-12 schools and 2 colleges enhanced their policies to be more comprehensive by always prohibiting the use of all tobacco products, by everyone, everywhere on campus.

Cessation promotion includes 10,441 calls to the quit services hotline, Baby and Me Tobacco Free participation, and 7 behavioral health facilities participated in the Missouri Tobacco Health Systems Change Behavioral Health Community of Practice.

- Tarkio passed a comprehensive smoke-free ordinance
- Salem passed a comprehensive smoke-free ordinance for all city-owned facilities and property, including parks
- 3 cities are working to pass a smoke-free ordinance

WOMEN'S HEALTH

Perinatal Quality Collaborative (PQC)

- 2nd cohort of the Maternal-Infant Dyad Affected by SUD and implementing Eat, Sleep, Console for infants born with NAS
- Consists of leaders across the state committed to improving maternal health outcomes
- First cohort included 22 hospitals participating in this effort, representing over half of Missouri births

Comprehensive Care for Women

- Goal is to increase the capacity of hospitals and other providers to offer care to moms with SUD
- DHSS will contract with University Health Truman Center and Mercy Hospital System in St. Louis. These will offer in-person and telehealth care to moms across the state using their network of hospitals and providers
- Care will include wraparound support to help moms with both their pregnancies, substance use disorder, social health needs, and other health conditions
- SUD is one of the leading causes of pregnancy-related death in Missouri

Related: Adverse Childhood Events (ACEs) such as experiencing violence abuse or neglect, or witnessing violence in the home, growing up in a homeless substance use, instability due to parental separation and incarceration, and adequate food, unstable housing and discrimination are linked to change in brain development and chronic health problems mental illness and substance abuse in adulthood.

Baby and Me Tobacco Free (BMTF)

- Served 133 individuals in SFY24. 93% of babies born were at normal gestation, which is better than the state average for all births at 89%. Preterm birth is associated with increased healthcare costs
- The women's health program uses telehealth to support moms across the state. Moms from 50 different counties received services.

COMMUNICABLE DISEASES

Disease intervention specialists (DIS)

Substance use, directly or indirectly, leads to increased transmission of HIV, STIs, and viral hepatitis.

DIS have been trained in harm reduction techniques and can leave behind naloxone kits, educational materials, risk-reduction supplies, and at-home HIV test kits.

Recent increases in syphilis and congenital syphilis, when a mom passes the infection to her baby during pregnancy or at birth, have been related to substance and injectable drug use. In its follow-up testimony, the department reported the number of early syphilis cases reported in Missouri increased by 345% from 2016 to 2023. Congenital syphilis increased from 2 in 2015 to 94 in 2023. A recently developed prevention strategy, Doxycycline post exposure prophylaxis, has been shown to reduce infections significantly. The group experiencing the largest increase in syphilis infection is white, heterosexual Missourians in rural areas this date. A contributing factor is injection drug use, particularly methamphetamine, with the related risk of passing the infection to babies.

For FY25, the legislature provided opioid settlement funding for three additional DIS positions, which will prioritize pregnant women diagnosed with syphilis or HIV to reduce the risk of transmission to the infant. These will be in St. Louis, Springfield, and the Kansas City area.

Office of State Courts Administrator. Eric Jennings, government relations counsel for the state supreme court indicated support for the Mental health treatment court legislation, the chair's sponsorship and the House passage thereof.

Richard Morrissey, Deputy State Courts Administrator. Discussing treatment court program appropriations.

A person volunteers to participate in the program and is provided with treatment resources and supervised through drug testing as well as directly, with statewide standards to follow to operate. In follow-up testimony, Mr. Morrissey indicated that OSCA staff is the process of recommending allocation strategy for funding to the Treatment Courts Coordinating Commission for funding treatment programs focused on medication assisted treatment for Missourians with SUV related alcohol and opioid addiction. These funds are requested to be awarded to treatment court programs in fiscal year 25. The Missouri Treatment Court program judicial circuit contact list is included in the exhibits to this report.

Missouri State Public Defender. Mary Fox and Annie Legonsky.

In representing about 80,000 cases per year, many come with SUD or mental illness, and all come with poverty issues. In 2022, Ms. Legonsky, who was working as an attorney and in treatment court, developed a program trying to connect clients to services by working with their attorneys. There is no state funding that is specifically for this program; we take in the funding we have for legal representation and have applied for grants to assist in this program. AmeriCorps program has been a huge help. Trying to bring this to every office in the state, which has 33 different trial offices; the ability to be connected with an advocate with the goal for these people not to become clients again. Too often, people come back. Once we meet them, if there is something they need, we can connect them. Plan to request 45 mitigation specialists to go into all offices, about $3 million per year, and they to connect clients with service in community, ensure transportation, and help with other needs.

After doing an evaluation of what has been done so far, an outside organization found that of the seven offices evaluated, there has been about $15 million saved in costs to the state, extrapolated to over $60 million statewide. It cannot be overemphasized the greatness of the community safety element, here, too.

IV. Hearing from September 26, 2024

Persons testifying: Dustin Hampton, Heidi Miller, Pat Simmons, Department of Health and Senior Services; Perry Gorrell, Department of Elementary and Secondary Education; Shawn Billings, EPPIC; Emily Kalmer, American Cancer Society; Brendon Steenbergen, Shelley Taylor, Marsha Hawkins-Hourd, Missouri Coalition of Recovery Support Providers; Anthony Mingo, Washington County Ambulance District; Ashley McDonnell, Dawnelyn Schneider, Central Ozarks Medical Center; Cynthia McDannold, Missouri Primary Care Association; Jill Taylor, Deanthony Henderson, Family Care Health Centers; Angela Kearns, Elizabeth Eye, Great Mines Health Centers

Department of Health and Senior Services.

Substance Use in Missouri. Drug overdose is a leading cause of death among Missouri adults aged 18 to 44. In 2023 there were 1948 overdose deaths, down from 2180 in 2022. The Missouri Patient Abstract System monitors non—fatal overdoses. In 2022 there were 10,783 nonfatal visits, more than half non-opioid related. In the fiscal year 2023, there were over 6000 EMS Naloxone uses. Southern and particular Southeast Missouri were found to be most vulnerable for opioid overdose and related blood-borne infections.

Prevention activities include contracting with the Missouri Hospital Association to support clinical education and harm reduction training. Between 2022 and 2024, approximately 8000 persons were trained for Naloxone distribution, and over 7500 Naloxone kits were provided to first responders and left behind, and over 39,000 with local Public Health agencies. In 2022 two thirds of all drug overdose deaths involved synthetic opioids (fentanyl). Fentanyl test strips have been distributed for harm reduction.

Substance Use Disorder Grant Program. In fiscal year 2024, four new recovery community centers, community and youth behavioral health liaisons, peer respite services and evidence-based youth substance use and alcohol abuse prevention have been implemented in conjunction with the Department of Mental Health; education materials have

been provided in programming for cannabis awareness with the Department of Elementary and Secondary Education; to the Supreme Court, medication assisted treatment to the treatment courts, veterans courts have been supported.

The cannabis prevention and education campaign will be launched by the end of the state fiscal year. Cannabis use among college students is up in 2024 to 32%, with edibles constituting 25%. Among middle and high school students, from 2010 to 2022, the percentage of students in grades 9-12 have ranged from approximately 10% to 20%.

Tobacco. Cigarette smoking is the leading cause of preventable disease and disability in the United States, and kills more people than alcohol, AIDS, car crashes, illegal drugs, murders and suicides combined. 11,000 Missourians die each year from smoking-related illnesses. Missouri spends $3.5 billion annually to treat smoking-related diseases with $7.1 billion lost on productivity, Missouri ranks number seven in the country for the number of adults who smoke. Smoking cigarettes is down with high school students, but e-cigarettes are up to 21.3%. Missouri's tobacco tax is ranked last among the states, at $.17 per pack, compared to the US average of $1.93. Prevention education strategies have been implemented with limited funding.

Drug use and related diseases. As we have seen substance use increase, we've also seen rising rates of viral hepatitis and syphilis, affecting different populations. Traditionally we would see this among gay men in urban areas, but now it's increasing in rural Missouri among straight white individuals, the compounding factor being injection methamphetamine use. It isn't just meth, most of the meth includes fentanyl, which leads to an overdose. DIS, which is across the state, investigates new cases of HIV or syphilis, ensuring people who are newly diagnosed are linked to care, or linked to HIV primary care, getting those to an undetectable level. People don't transmit to other people at that point. Providing test kits to determine status and get them into care.

Congenital syphilis has become a big concern nationwide and across the state; in 2017 we had 2 cases of congenital syphilis, and there was a conversation about missing the opportunity to treat it. Now we have 94 cases, across urban and rural areas, across all demographics, impacting the entire state. Some of the big compounding factors include substance use and lack of housing instability. There is a statewide syphilis advisory group and congenital syphilis review board to review missed opportunities to intervene. Mom needs to get treatment started 30 days before delivery in order to become 100% preventable.

Treatment regimens exist for babies born to moms with HIV don't contract the virus, so we want to continue getting those moms into treatment, doing so by working with partners across the state, local health agencies, FQHCs, nurses providing treatment in the field, and maintaining regular contact with moms to find her on a weekly basis to meet with the nurse to get treatment.

Approximately 32% of people injecting drugs become positive with Hep C within 1 year, and 53% contract it within 5 years. Our programs have provided rapid point-of-care antibody testing, and there is little federal funding for this, but CDC has provided some funding to allow for confirmatory testing through the state public health lab for the first time. It requires a second test to determine infection, and in this last session, we received a little over $288,000 from the Opioid Settlement Fund to help supplement. This will fund about 11,000 kits working with ERs, LPHAs, and FQHCs to provide that testing. Working with Mizzou ER to implement opt-out testing, where everyone should be tested at least once, and this is a standard test provided to everyone unless someone says no. These are good ways to find people who didn't know they were at risk, as it can be silent for many years.

Controversy over programs. Some of the things that have been controversial to this body, like syringe services or harm reductions, are very effective and studied ways to prevent hepatitis and HIV. As people access services, they're more likely to get health care and SUD treatment, as they have welcoming places to come in, they're more willing to try to stop using.

One recommendation we did submit is funding for doxycycline, going back to STDs. It's recognized as a regimen for doxy-pep, preventing chlamydia, gonorrhea, and other infections. We work with 180 sites to provide STI testing and treatment, LPHAs and FQHCs, and other places that could provide clean needles in the future.

We are working with DSS and MO HealthNet to get people treated for Hep C to prevent future transmission, with patient navigation to newly diagnosed people, our goal is to drastically reduce the number of cases across the state.

Graduate Medical Education Program, Pat Simmons

- Two considerations:
    - Current shortages in health workforce
    - Availability of workforce to provide needed services to treat SUD.
- Missouri has 900 health professional shortage areas (HPSAs), 295 of these being mental health, so there is a need to add at least 600 primary care physicians and over 100 psychiatrists. Missouri exports nearly 1/3 of our medical students to residency programs in other states. We need over 350 residency slots to get our students to stay in the state. Physicians are likelier to stay in the state in which they trained, and over half of students who complete their residency here ultimately stay to practice.
- Addressing the consideration on treatment services, about 1 in 7 people diagnosed with an SUD got treatment. The main driver is a reluctance to treat, which is influenced by a lack of training in medical school and residencies.
- In 2023, the Missouri legislature established a grant program to support expanding existing residency programs. In the first year, the department awarded 5 grants, supporting 9 new slots for the duration of the resident's training period, with $2.2 million. Additional funding will be required to continue the Graduate Medical Education program. Over the next 10 years, this program will support over 90 new residency positions.
- GME programs receiving grants and contract dollars have a new training requirement, including for addiction training, established in response to the high prevalence of SUD.
- Also working on additional partners, key stakeholders in GME partner groups, and other state departments.
- New programs support new accredited residency programs in primary care or general surgery, with 8 weeks training in addiction and 8 weeks of training in a rural area. This helps sustainable expansion of rural facilities.
- We need over 1000 physicians, with states needing to take it into their own hands. Wisconsin generates over 140 new graduates per year with in-state retention and rural retention. Over 2000 lost physicians are expected. Some states have not invested in GME, we're starting with 9 per year. We are scrambling to make a difference, an evidence-based way to increase the workforce.
- We also need to work on retention, encouraging it, by loan forgiveness, which is key to the cost of medical education. We are adjacent to eight other states, and our two largest metropolitan areas easily hemorrhage to other states. Kansas has a very robust loan forgiveness program, for example. Our own loan forgiveness program is just not enough at this point. J1 visa waivers are restricted to 30 per year, which is a brain drain for us. We are training international medical graduates, who are home-grown trained in MO, then we send them back. We need more J1 visa waivers, which is a federal issue.
- In connecting communicable disease and SUD, the key example is congenital syphilis. If a woman is addicted to substances and pregnant, she is less likely to get prenatal care. Also, about Hep C, many people can have it and not know it. It is life-threatening, but it takes a while to get sick and die from it. The rapid testing can lead to being cured in 8 weeks, and it enables those folks not to transmit it.

Missouri Primary Care Association.

Missouri Primary Care Association (MPCA) is the member organization for Federally Qualified Health Centers (FQHC) in Missouri. Beginning in fiscal year 2024, the SUD Network Grant, Funding program has seen patients grow from 1031 in Q2, to 2494 in Q4. The goals are to increase the number of individuals connected to substance use treatment, build community partnerships to provide access for community resources to support prevention, treatment recovery, and establish referrals and feedback loops between FQHCs and other partner providers. The Network program provides collaboration with hospital systems to facilitate patient transmissions from hospital care to outpatient services by embedding FQHC staff at hospitals. The partnership with nonprofit CCBHCs provides transition housing, using peer specialists and Community Health 30 workers to engage in employment, transportation and develop life skills. Most recent fiscal year funding allows expansion of the network program from 5 to 8 health centers. In total, total common in 2023 there were 200 FQHC clinic sites, with over 2 million patient visits, and over 9000 patients receiving medications for opioid use disorder. Over 50% of FQHC patients are HealthNet members, and 16% were uninsured.

One network site, for example, Central Ozarks Medical Center, distributed over 7000 Narcan doses, over 2000 fentanyl test strips and held over 1300 school-based behavioral health visits. Medication Assistant Treatment appointments in 2023 were nearly 2000, and treatment court services in the form of group therapy and individual therapy, peer support and MAT were provided, and mentor peer support coaches were provided in coordination with EPICC. A significant effort is wraparound services that support housing, rent assistance as well as recovery treatment. Similarly, Great Mines Health Center was involved with the 24th Judicial Circuit Treatment Court serving to date 166 participants with MAT, behavioral health, other healthcare and wraparound services and cognitive behavioral therapy. Treatment court graduation rates are 33% at the family treatment court program and 80% with the adult/DDR/veteran court treatment programs.

With regard to the critical need of transportation, Washington County's ambulance district's Mobile Integrated Healthcare network in partnership with the ambulance district and the FQHC is the first of its kind. The mobile integrated healthcare network provides medical and non-medical services, including transportation, access health insurance coverage, insecurity, telehealth appointments, nonemergency transportation and public health.

DESE

- Maternal substance abuse training:
    - Parent education programs, overseen by Office of Childhood.
    - Federal grant received through DMH, in year 4 and approaching the end of the grant.
    - FY24, expended $195,000. This year's budget has a new decision item to allow us to spend about $560,000 to get the remaining funds spent in fiscal year 2005, attendance and impact measures will be used to measure efficacy.

- Recovery high schools, currently 24, Secondary schools designed for students recovering from SUD and co-occurring disorders, these share the following goals:
        - Educate and support students.
        - Meet state requirements for diplomas.
        - All students are working on a recovery program for SUD.
    - $500,000 appropriated but could only be spent in Clay County. We had no one within Clay County who accepted the application. These are for wraparound services, most of which comes from DMH. We are to oversee the operation of the school, and DMH is about the other supportive services.
    - New geographic locations in 29 counties to be eligible going forward.
    - DMH using opioid settlement funding is what will help with sustainability, but it isn't guaranteed.
    - Recovery high schools have shown 20% higher graduation rates, 17% lower dropout rates and twice the likelihood of complete abstinence. Any metro area high school with SUD recovery can apply and students 18 years and older may self-refer.
- Health investment fund:
    - New to us this year, partnership and MOU with DHSS, education resistant materials, intentions being to support programs across the state and working on an MOU with a nonprofit that oversees all the training across the state. The cohort that does it is made up of 30 people and costs about $70,000. We want to expand resources for that entity.

EPICC (Engaging Patients in Care Coordination)

- Community health needs assessments are done to derive benefit for nonprofit hospitals every few years. Sample was 75 hospitals, and the big concern is behavioral health, by far.
- Mission: provide 24/7 referral and linkage to services for people who use drugs who present to a hospital for an overdose or other substance use crisis to establish immediate connections from the hospital to community-level care coordination. Peers have been there, done that, and have that knowledge. The model is framed on evidence-based model known as SBIRT (Screening, Brief Intervention, and Referral to Treatment)
    - Screening;
    - Overdose education/naloxone distribution;
    - FDA approved medications for SUD;
    - Warm handoff with recovery support; and

    - Connection to treatment for SUD.
- EPICC has 38 hospital partners around the state, and 27 community partners, divided among its six regions. There are 390 average monthly (4602 referrals in fiscal year 2024) referrals between EPICC and its partners, service by its approximate 35 Certified Peer Specialist. Additional funding in fiscal year 25 allowed the hiring of five additional Peer Specialists. He
- Programming goals
    - Addressing social determinants of health, such as housing, food, transportation, and other barriers to recovery support and treatment;
    - Integrating harm reduction practices into programming, such as providing individuals overdose education, opioid overdose reversal medications;
    - Connecting people to recovery community centers and other recovery supports to establish pro-social outlets; and
    - Linking individuals to evidence-based substance use treatments.
- What's working well
    - Easy process for referral;
    - Peer recovery coaches with lived experience;
    - Timely response at all hours;
    - Warm handoff;
    - Individualized support and case management; and
    - Connections with service providers in the community.
- Importance of opioid overdose reversal medications and medications to treat alcohol and opioid use disorders
- The "Care Cascade" for patients with OUD and serious injection-related infections
    - Objectives
        - To define the care cascade for patients in a tertiary hospital system and compare outcomes of those who did and did not participate in an OUD treatment referral program.
    - Results
        - During the study period, 334 people who inject opioids were admitted. 14 admitted patients died and were excluded. The all-cause readmission rate was lower among patients referred to the EPICC program (23.7%) compared to those not referred to EPICC (41%).
        - Conclusion. An OUD care cascade evaluation demonstrated that referral to peer recovery services with outpatient OUD treatment was associated with a reduced 90-day readmission rate.
- Looking Ahead in 2025
    - June-July 2024
        - Provide technical assistance and ongoing support to the newly established EPICC program in the SE region.
    - July-September 2024
        - Support EPICC enhancements in the central, SW, and western regions, i.e. assisting with the onboarding of five additional certified peer specialists.
    - October 2024-March 2025
        - EPICC staff will be offered specialized maternal health training via the Missouri Credentialling Board, i.e. Pregnant and Parenting Families.
    - Spring/Summer 2025
        - Convene third annual statewide EPICC convening.
    - Q3 2025
- Support statewide EPICC evaluation, with timelines contingent on securing and sustaining necessary positions to conduct program evaluation.

American Cancer Society

- Tobacco is the number one cause of preventable death in the US.
- Economic impact:
    - $3.25 billion in direct health care cost including nearly $700 million in Medicaid costs;
    - Smoking costs $7.1 billion in productivity costs annually; and

  - On average, Missourians pay $1203 per household in state and federal taxes from smoking-caused government expenditures, whether they smoke or not.
  - In FY 2023, Missouri budgeted 2.9 million dollars for tobacco cessation and prevention, increased by $350,000 in FY 2025. By contrast, tobacco marketing in Missouri is 344 million per year.
- Effective policies
  - Significantly increasing tobacco excise taxes on all products. As of July 1, 2024, the average state tax is $1.96, Missouri's is $0.17.
    - Should be more than $1 increase. Impact use, initiation by youth, and lead to quittance.
    - The tobacco industry has all sorts of strategies to mitigate some minimal taxation increase.

Coalition of Recovery Support Providers (Recovery Support Services (RSS) providers and Recovery Community Centers (RCC)

- Distinction between addiction recovery treatment and recovery support services
  - Importance of understanding addiction recovery strategies:
  - Addiction recovery treatment:
    - Clinical interventions for immediate symptoms (detox, counseling, MAT);
    - Conducted in residential or outpatient clinics; and
    - Significant investment.
- Recovery support services
  - Non-clinical, community-based support after treatment.
  - Types:
    - Peer recovery coaching;
    - Sober housing;
    - Employment and education support;
    - Transportation services; and
    - Family and social support.
  - Delivered in non-clinical settings like RCCs and peer networks.
  - Research shows RSS reduces relapse and promotes long-term success.
- Recovery community centers:
  - Peer-run organizations providing support and resources.
  - 12 RCCs in Missouri, serving over 24,000 people annually.
  - 5 peer respite crisis stabilization programs served 1,401 unique people.
- Missouri recovery support service programs:
  - Designed to follow treatment services; and
  - 60 DMH contracted RSS providers and 5 access sites by the end of 2024.
  - At the end of 2022, recovery support services had 205 houses with 2304 beds. In 2023, Recovery Support Providers accredited 53 new houses and 624 new beds, with a total of 3392 individuals served in recovery housing in 2023.
- NARR Accreditation:
  - MCRSP accredits recovery residences in the state.
  - Growth in active houses and beds.
- Evidence supporting RSS:
  - 50% more likely to remain abstinent with peer recovery support.
  - Combining housing support with coaching increases employment rates.
- Cost of relapse without RSS:
  - Cycle of treatment episodes, ER visits, incarceration.
  - Government costs: criminal justice, health care, and assistance programs.
- Benefits of RSS: Rebuilds lives and self-reliance.
- Financial Needs and Justifying Additional Funding:
  - Need for increased funding:
    - Current gaps: regions deferring assistance due to exhausted resources.
    - Request for additional $6 million towards RSS Services:
      - Ensuring access to existing sites and expansion to rural areas.
    - Request for $3 million for Recovery Community Centers:

- Sustain and expand crucial hubs of recovery.
- Open new centers in underserved areas.

- Comparison with other states:
  - Missouri has 12 RCCs, Massachusetts has 39, and Georgia has 25.
- Outcome statistics for individuals in RSS services at six-month follow-up:
  - 84% abstinent from alcohol and illegal drugs.
  - 97% in stable housing.
  - 73% employed or in school.
  - 98% with no new arrests in 30 days.
- Research by John Kelly, Harvard Medical School:
  - Ongoing recovery support services reduces time to reach quality of life from 15 to 5 years.
- Return on investment:
  - $1 spent on recovery services saves $7 in healthcare, criminal justice, and productivity costs.
  - Individuals in recovery contribute to the economy (jobs, taxes, family and child support).

- Final Key Points:
  - RSS and RCCs are not luxuries, but necessities;
  - Additional funding is critical for addressing the addiction epidemic;
  - The combined effort of state, nonprofit, faith-based leaders, community programs, peer-led support groups, and civic facilities is crucial; and
  - Investing in recovery services saves lives, strengthens communities, and makes MO a model for long-term recovery support.

V. Hearing from October 29, 2024

Persons testifying: Melissa Kroll, Washington University; Rachel Winograd, Greg Boal, Jameala Jones, University of Missouri-St. Louis; Clay Goddard, Amanda Mays, Brightli SW Region/Burrell Behavioral Health; Scott Allen, Ashley Dedmon, Lora Smith, Webster County Health Unit; Sue Haverman, Catholic Charities St. Louis

Treatment in Place and Alternative Destination for EMS Melissa Kroll, M.D., Washington University

Innovating EMS systems to better fit into healthcare systems. I was leading these discussions for the National Association of EMS Physicians, experimenting with federal pilots. I want to bring that back here to MO; I think this is something benefitting us here. To understand this better, we need a better understanding of what EMS looks like.

EMS only gets reimbursed if they transport. That system is a good one, but not the majority of EMS calls; up to 65% of emergency department calls didn't need to be seen in an ER at all. Also get called for things like anxiety, high blood pressure, alcohol abuse, things that require access but don't need to be treated in an ER.

Paramedics and EMTs go through hours, sometimes months, of training before going on an ambulance. They give reports and communicate with health systems, so we want to provide better ways for those systems. We want to offer more options and more locations for transport. It doesn't take an ER doc to schedule a dentist appointment. We can have paramedics identify what's happening, and they do the necessary service. There was a federal pilot program on this in 2020, allowing for reimbursement for the transport to an alternative destination. It also allowed EMS to be reimbursed for in-home consultations. That patient could be assessed by someone at home, get scripts sent to their pharmacy, all without leaving. Over 100 agencies applied, and it was found to be safe in all of them.

The other thing is that patients enjoy additional options, 90% of patients reported having really liked it, and would recommend this type of system for themselves, families, and friends. Also, quite a bit of savings; going to the ER adds cost, and by making things more efficient, we can boost savings. A cost evaluation of the program found savings when allowed to use systems more flexibly, after the EMS was paid, after the physician was paid, and after the urgent care visit was paid after all were reimbursed.

This has been adopted in many states, adopting reimbursement models. TX, CA, GA, KY, MN, etc. We have a limited form of this pilot in MO, and we can do alternative destination and treatment in place for psychiatric and behavioral health calls. This has made a world of difference, but doubly so from a patient's perspective. We have a

better option. Crews spend time talking to the patient, connected them directly to a counselor through a behavioral health line, all while keeping the patient in home.

Another population we forget about is those who refuse to go to the ER, with about 35% of all nationwide calls ending in refusal. A lot of patients refuse even with real health problems. More healthcare gets to those who need it without them getting into a critical state, where the only option left is to get to the ER.

My request is this: We know the EMS system works in certain scenarios, but it could work better. At some point, this pilot program is going to end. My request is that when that time comes, we reconsider making this more permanent. My second request is expanding this to allow it to happen to all patients.

2021 – 2022 Booz-Allen study: federal pilot project and treatment in place and alternative destination demonstrated a net savings per intervention of between 514 and $570.
Benefits: it keeps patients in their homes; it keeps EMS within their communities and available for the next emergencies: patients have more options; appreciate those options; more efficient use of scarce EMS resources saves money.

University of Missouri St. Louis Addiction Science Team Dr. Rachel Winograd (Director of Addiction Science), Greg Bowl, and Jamella Jones.

We're going to talk a lot about the opioid overdose crisis. That's the nature of our work, the biggest priority, and opioids drive over 75% of drug-involved deaths. There are many laudable programs here across the state, we want to stay high-level, and hitting the high points on drug use, addiction, what makes it worse and better.

Our team would not exist without the support and partnership from state agencies, particularly DMH and DHSS. Through genuine collaboration and funding, our team has grown to address many of the problems. We're not here to represent the views of DMH or DHSS. I've learned a lot being a part of this committee; I know you all wear many hats as legislators, so you have a lot of power to change how we treat people who use drugs in our state.

I want to start by giving a brief lay of the land regarding the overdose crisis in this country. I'll keep this relatively short, but most of us are familiar with the crisis beginning in the 90s, initially driven by prescriptions. We've transitioned from a pill-dominated crisis, from heroin, to fentanyl. It's a potent synthetic opioid, it is not evil, and we should not panic, but illicitly made fentanyl has taken over our drug supply.

Trends move east to west, and Missouri tends to follow the East coast and Appalachia regarding drug trends. We're seeing those decreases in drug related deaths fall in a geographic pattern, such that decreases move east to west, but you can take that national example, and it works here. St. Louis will always get hit with something first. We did see a decrease of over 10% nationally in 2023, and looking at preliminary 2024 data, that decrease is continuing.

Missouri tends to fall around national average patterns; we had an 11% decrease, and in 2024, we have some good news: we are seeing a 28% decrease in the first half of this calendar year. Anyone who says they know exactly why they're seeing the decrease doesn't know; it's multi-causal, and in public health, we talk associations not cause.

St. Louis has been the epicenter of our state's overdose crisis for a long time, and Black men, when talking demographics, are hardest hit. There is evidence of decrease, but rates of death among Black men are 3x higher than those of the general population. Some populations, regions, demographic groups need more support if we want everyone to get out of it.

Exercise by Dr. Winograd – she asked everyone to write down their drug of choice and then write out positive effects of that drug of choice. She explained that caffeine, gambling, alcohol, and high-sugar and fat foods can all be considered drugs. She then asked to cross off the drug of choice, then relabel the list as "My Needs."

People have said patience, creativity, relaxation, social engagement, pain relief.

When you look at a list like this, we use drugs to meet our needs. Humans are rational. We don't continue doing things if they do nothing for us. We all have reasons for engaging in this behavior. So often, we try to get people to

stop using drugs or to reduce their use, but we don't acknowledge that we're asking them to take away a form of getting their needs met. We want them to go without their needs being met without replacing it with something. I bring this up to ground us in the reality that people use drugs for reasons, and most often it isn't just to "get high." Please keep this in mind, if we're taking something away, we need to be ready, willing, and able to replace it with something to help people get those needs met.

Really important not to minimize the horrors of opioid withdrawal. People end up using just to feel normal, because the base state is in this feeling of dope sickness or withdrawal. People have said they've been shocked at what they've seen themselves do in a state of withdrawal.

These medications help keep people in the "white zone". Because people can take them once per day and doesn't allow people to spend their whole day chasing their next dose, it allows people to go and live their lives. Heroin use was 3-4 injections per day, fentanyl is around 12.

Medication for OUD is lifesaving. Hospital initiation of MAT should be abundant in every hospital. Long-term care in primary care settings is possible.

What tangible tools and strategies do we have to save and improve lives of people who use drugs, and all of those impact by addiction?

- To save lives and reduce harms
  - Community-based naloxone distribution:
    - Aiming for saturation;
    - Prioritizing distribution to people who use drugs and are likeliest to be at scenes of overdose;
    - Diversifying access options; and
    - Teaching compassionate responses.
  - Opioid-agonist medications for OUD:
    - Increasing availability of methadone and buprenorphine;
    - Prioritizing rapid and sustained access; and
    - Diversifying access options.
  - Syringe access programs:
    - Providing physical space and interpersonal support;
    - Reducing transmission of HepC and HIV; and
    - Increasing likelihood of people entering substance use treatment.
- To improve lives and well-being:
  - Housing, transportation, and other basic necessities:
    - Increasing availability of securing housing to enhance stability;
    - Increasing access to transportation to engage in treatment and employment; and
    - Providing reliable access to other life necessities.
  - Peer support and community connection:
    - Offering peer and community recovery support services help prevent return to drug use;
    - Increasing the percentage of people who are in sustained and stable remission, reducing the number of people at risk of overdose; and
    - Providing peer-to-peer role modeling and hope to sustain positive changes.

Medication First Approach

- People with OUD receive medical treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are offered but not required as a condition of pharmacotherapy; and
- Do not discontinue medical treatment unless it is clearly worsening the patient's condition.

Individuals enrolled in MedFirst were more likely to:

- Receive medication;
- Get medication sooner;

- Receive fewer psychosocial services;
- Be engaged in treatment at 1, 3, 6, and 9 months; and
- Cost the state 21% less per month, on average

Naloxone saturation is a concept we can make into reality: we want it to be already at the scene if someone overdoses. Yes, call 911, but we don't have the luxury of time to wait for EMS. Usually, other drug users are the ones who are there at the scene of an overdose. We want people most likely to witness an overdose, which tend to be active drug users, to be the ones carrying it. Despite fears and claims otherwise, giving out naloxone does not increase drug use; it increases the likelihood that someone will survive a lethal dose of opioids.

Greg Bowl

What we do for first responders is provide statewide technical assistance, naloxone for administration, and more importantly, leave behind Narcan bags in order to provide additional levels of care, and make it less likely for someone to overdose lethally in the future. What we have found is that it's not just good for the people in the community struggling with substance use, it's also incredibly beneficial for our first responders as well. By giving them this extra tool, they have lightened their burden substantially. We have three main effects:

- Trying to increase first responders' ability to save lives by giving them naloxone and instilling the confidence that naloxone is safe to administer;
- Reducing the workload on first responders by giving them less to do; and
- Wanting first responders to deal with less stress, burnout, and risk when they do have to respond to such calls.

EMS doesn't get reimbursed for this type of thing. So opioid settlement fund dollars are helping to fund these EMS agencies, and EMS agencies want to have the medication paid for, and then maybe some funding for staffing. The only reimbursement would be if they transported that person somewhere else. We should figure out the technical aspects of the funding. Every EMS agency could do this now is kind of how it's been put. If that's the case, we should ramp it up. A big reason we haven't gone that route is because we had expected the money to run out in September. And that was Dr. Kroll's request, to not have it be a pilot anymore, and make it the law so that people could do alternative transportation and care at home. The end state should be that any EMS agency can do this.

The culmination of our qualitative research study is represented in the physical flier's figure, and at the end of the day, what we developed was the Four S model:

- Safety
- Security
- Stability
- Survival

A lack means of any of these means we're living in crisis mode every day. When people live in this type of environment day-to-day, their drug addiction is likely the least of their concerns. These drivers, summarized by these Four S, allow us a ticket out. If we can address these needs, then people can start focusing on their priorities.

Missouri Peer Respite Crisis Stabilization Initiative.

Homes across MO were built specifically to fill the gaps. They're not recovery housing, for which people need to be sober and in treatment – these are for people who are in crisis, low barrier, community-led, have food, beds, and let people stay there to get themselves together before connecting them to whatever resources are required. Over 2/3 of participants in these centers move on to a more secure form of housing at the end of their stay.

People found money to keep this going, and it's a promising model that addresses the overdose crisis as well as people needing their basic needs to be met.

Along with this concept of basic needs, I would be remiss not to mention prevention. I am not an expert in prevention science, but I want to get you to think broadly about youth use.

When talking about the most effective way to reduce long-term SUD, it's investing in environments and communities. Free breakfast, lunches, and after school care. Summer care, childcare. Stable places to live without moving from home to home. It's a rich environment, where children who have these protective factors are much less likely to initiate substance use. Improve child development, support families, and enhance experiences.

WHAT SHOULD WE DO?

- Reach and maintain true naloxone saturation:
    - Ensure funding stays level or is increased;
    - Encourage agencies and organizations to build naloxone into their budgets, long-term; and
    - Prioritize distribution to settings and programs most likely to interact with people actively using drugs.
- Allow syringe access programs to operate legally across the state:
    - Can be access "hubs" for several medical and behavioral health resources (naloxone, treatment referrals, social services).
- Make buprenorphine and methadone easier to get than fentanyl:
    - Support any and all efforts to increase provision of these treatment medications across settings; and
    - Promote medical treatment for OUD within and outside of traditional substance use treatment facilities.
- Ensure people have their basic needs met – particularly housing and transportation:
    - Focus on Four S: safety, security, stability, survival for all Missourians;
    - Increase availability and access to housing across the spectrum (peer-run crisis stabilization, recovery housing, transitional housing, low-income housing, etc.); and
    - Fund and otherwise support transportation access (public transportation, vehicles for organizations, vouchers, etc.).
- Invest in peer and community-based support to promote sustained remission and positive social networks:
    - Remove any and all barriers to service delivery and coaching support from peer support specialists and community health workers across care settings.

Ensure people in these roles are employed, and paid equitably, across care settings, with opportunities for career growth and advancement.

(Over 25 pages of the UMSL Adduction Science Team materials detailing their testimony, with 5 pages of references to over 70 scientific reports are included in the references and exhibits to this report).

Brightli SW Region. (Includes Burrell Behavioral Health), Clay Goddard.

Burrell's Recovery services have provided services to over 7,000 clients this FY. Our recent successes include identifying gaps in care as well.

Transition to ASAM (American Society of Addiction Medicine) model: To treat clients with SUD, recovery service providers offer a continuum of services based on individual client needs and strengths. Need to convert from the CSTAR program levels of care to ASAM levels of care. They were ready to go live in April of this year, three months before the deadline, reflecting evidence-based solutions. Early results are promising, as more clients are participating in treatment. This level of care is embedded in the residential model and requires certain placement criteria to be met by clients. The old-school setting of detox only led to about 5% seeking treatment in other service lines, but through withdrawal management, up to 60% seek additional treatment.

Withdrawal management could serve as a bridge between people with SUD and residential treatment programs, with data seeming to support this as well. Also continuing to streamline processes of getting clients to treatment services and working in partnership with people in rapid access units. Intent is to transition clients from withdrawal management to full participation in residential services as quickly as is capable.

In Springfield, there are more resources available for people in need, by making this conversion to ASAM to a total of 24 beds, increasing accessibility to lifesaving treatment care. Over the past FY, clients were provided with over

6000 services, including wraparound for those in recovery; group education, peer support, inpatient care, co-occurring services, and individualized therapy.

Providing MAT to clients, which has gained more attention, is a path to combating OUD and other SUDs. When medication curbs cravings, the teams can address underlying issues relating to substance use (connecting to food or housing, working through trauma). This comprehensive approach promotes long-term recovery, developing healthier coping skills to self-medicate. MAT can also successfully address alcoholism.

864 referrals, 48% for stimulants, primarily meth in SWMO, 30% were for alcohol, 7% were incomplete data, 15% for opioids. The team tries to get overdose victims location, and within an hour of learning of the report, get them out on the street and act with urgency.

ICTS: Improving Community Treatment Services – this includes working with repeat offenders, resource-rich programs, and helping clients transition out of vicious cycles and outside of barriers they may face. Though successful program participation is a requirement of getting those services, emphasis is placed on housing, employment, and aftercare, based on accountability, taking into consideration public safety and the delivery of recovery outcomes for participants; teaming together with parole and probation partners to help many of these clients reach successful outcomes, frequent random drug tests, addressing behavioral issues head on, and treating people like people.

Lack of access to stable housing: need outpaces the availability and variety of housing available. There is no family-friendly housing, for example, that would allow a client to have his or her children living with them, and no housing for clients designated as LGBTQIA+.

One program that has shown program is the CARES Grant, funded through SAMHSA, that assisted women with SUD to get housing and employment, with a goal of helping 250 women, referred to as a "massive undertaking." Property managers are also reluctant to lease to people using drugs, or who are in recovery. Wanting to reduce episodes of incarcerations, CCBHCs across 7 counties in SW Missouri, and 10 counties in central MO, all saw a significant increase to 716 in FY 24; crediting a statewide effort to host collaborative workshops and local leadership, mapping how adults with mental health issues and SUD move through the legal system. Intercepts include mobile crisis outreach teams, training to help law enforcement, screenings at jails, identifying those who need care earlier, specialized treatment courts, and a warm handoff from jail to community services to ensure people are adequately connected to what they need.

Mapping workshops identified more outreach to more community partners, and what resources are available to tap into when the need arises, part of an overall effort to work upstream with partners.

Webster County Public Health Unit, Scott Allen, Ashley Deadman, and Laura Smith. Webster County health administrators.

Many students use over the counter medications to get high. 30% see no harm in using e-cigarettes or alcohol, and a close amount see no issue with daily use of marijuana.

We know all too well that folks with SUD have cooccurring mental health conditions.

Prevention is prevention is prevention, so an overarching goal should be to raise a generation of younger people that makes better choices with what they do with their lives and their bodies. It's hard, since it's different for every community. Developmental assets, we know that if youth have ties to their community, a trusted adult outside of the home, they're less likely to participate in riskier behaviors.

Webster County has developed a community partnership, which brings together the county's health, behavioral health and social service providers. Three years ago, the county had a backlog of over 80 students waitlisted for behavioral health services. Working with Burrell, the list was eliminated in one month. A 2022 study of the national Institute on Drug Abuse showed that a $602 investment in youth prevention activities yielded an estimated $7754 in savings by the time the participants reach age 23.

Our job in prevention is to work even further upstream, in our County starting in preschools, following the Institute of Medicine's continuum of care: promotion, prevention, treatment and recovery from my perspective. Little state general revenue funds take their way into prevention efforts. We're looking forward to working with the task force to address this. In Webster County we have pursued outside grant opportunities, receiving a grant from the Department of Mental health of federal pass-through funds to address prescription medication opioid misuse, as well as receiving a Drug Free Communities grant from the CDC.

Ashley Dedman is a project director on a five-year grant for which Webster County was awarded $125,000 per year and may apply for an additional five-year renewal. There are two program goals: community building and to reduce youth substance use. We were required to identify two priority substances, and we selected medication safety and marijuana, due to the recent passage of the adult-use marijuana laws. There are 22 community coalitions with the grant. We are required to match the federal dollars 100% in years one through six and 150% by year ten. Webster County also has a Missouri Foundation of Health Diversion to Care research grant. Laura Smith is the project director. The grant allows research into how substance abuse and behavioral health are handled to determine what barriers exist, as well as opportunities for improvement. Such opportunities can be establishing more resources, making them stronger, and bringing awareness and training. The grant has four goals, including examining the behavioral health crisis and identifying diversion approaches. Webster County participated in the SIMM sequential intercept project and identified four priorities: justice/mental health collaborative and crisis intervention, prevention, skill building and navigation. The grant is building awareness of needs. We're partnering with our state representative to provide outreach and treatment information, and promoting 988, and gathering input to create and design for prevention. Continuum of care can be best served working collaboratively, avoiding the prevention and treatment silos. We're working in Webster County to eliminate silos and seek innovative ways to fund this critically important work.

Catholic Charities St. Louis, Workforce Development Director Sue Haverman

What I see is that people think we can work miracles. We frequently see people with mental health issues. I've gone to the extent of actually begging for a mental health specialist, which was obtained, and who is shared with another group (St. Patrick's Center). Queen of Peace serves 1000 people per year and refers people back and forth. A lot of times, women get referred to Queen of Peace for drug counseling, assistance, and support. They are referred after getting off drugs.

We see about 120-160 people per year, and 50% are justice-involved. Of those, another 20-30% have either mental health issues or SUD. We provide them with housing, one of the first things we do, and sometimes the case managers send them to mental health, or substance abuse, or where they need to go.

There are a variety of housing programs, intake, and it depends on what the person needs, where they get referred. For instance, if you are in need of housing right away, there is a short-term transition program, if you're a veteran, you could get to one of the 5 veterans' programs, if it's long-term you'd likely go to the HERO program, and the long-term transitional programs that are more for people who have chronic, co-occurring, issues with mental health and/or substance use.

Would ask for recommendation to make equitable the amount of tax credits that would be available as for pregnancy care centers (no limit on the amount of credits); need to know if there is a cap on the Neighborhood Assistance Program (NAP) and Youth Opportunity Program (YOP) grants.

POLICY RESEARCH

What are the public health outcomes of cannabis legalization?

Research studies on the long-term outcomes of legalizing cannabis on public health are not consistent and therefore inconclusive. Research is generally divided into work focused on medicinal cannabis legalization (MCL) and recreational cannabis legalization (RCL).

	Effect of MCL	**Effect of RCL**
Youth cannabis use	• Some studies suggest increases consumption[3] • Other studies find no impact[4]	• Remains unclear; requires more time for further research and comprehensive analysis[5]
Alcohol and cigarette use	• Associated with a rise in adult binge drinking [4, 6] • No impact on youth alcohol consumption [4, 6, 7] • Reduction in teen cigarette use[8]	• Linked to a decline in college students' binge drinking[9] • No effect on college students' cigarette use[10]
Opioid use	• Reduced opioid prescriptions[11, 12] • Unclear impact on opioid related mortality[13, 14, 15, 16]	• Reduced opioid prescriptions [11, 12] • No impact on opioid related mortality[16, 17]
Other substance use	• Decline in heroin-related treatment admission, as a result of cannabis substitution[18] • Decline in prescriptions for mental health, pain, and neurological	• Reduction in sleep-aid sales[20] • Little evidence of impact on harder drug use, treatment admissions, or crime rates[21]

[3] Hollingsworth A, Wing C, Bradford AC (2022) Comparative effects of recreational and medical marijuana laws on drug use among adults and adolescents. *The Journal of Law and Economics*. 65(3):515–554. https://www.journals.uchicago.edu/doi/full/10.1086/721267
[4] Wen H, Hockenberry JM (2018) Association of medical and adult-use marijuana laws with opioid prescribing for Medicaid enrollees. *JAMA Internal Medicine*. 178(5):673–679. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2677000
[5] Anderson DM, Rees DI (2023) The public health effects of legalizing marijuana. *Journal of Economic Literature.* 61(1):86–143. https://www.aeaweb.org/articles?id=10.1257/jel.20211635
[6] Veligati S, Howdeshell S, Beeler-Stinn S, Lingam D, Allen PC, et al. (2020) Changes in alcohol and cigarette consumption in response to medical and recreational cannabis legalization: Evidence from US state tax receipt data. International Journal of Drug Policy. 75:102585. https://doi.org/10.1016/j.drugpo.2019.10.011
[7] Andreyeva E, Ukert B (2019) The impact of medical marijuana laws and dispensaries on self-reported health. *In: Forum for Health Economics and Policy*. 22(2):20190002. De Gruyter https://doi.org/10.1515/fhep-2019-0002
[8] Anderson DM, Matsuzawa K, Sabia JJ (2020) Cigarette taxes and teen marijuana use. *National Tax Journal*. 73(2):475–510. https://www.journals.uchicago.edu/doi/abs/10.17310/ntj.2020.2.06
[9] Alley ZM, Kerr DCR, Bae H (2020) Trends in college students' alcohol, nicotine, prescription opioid and other drug use after recreational marijuana legalization: 2008–2018. *Addictive behaviors*. 102:106212. https://doi.org/10.1016/j.addbeh.2019.106212
[10] Alley ZM, Kerr DCR, Bae H (2020) Trends in college students' alcohol, nicotine, prescription opioid and other drug use after recreational marijuana legalization: 2008–2018. *Addictive behaviors*. 102:106212. https://doi.org/10.1016/j.addbeh.2019.106212
[11] Bradford AC, Bradford WD, Abraham A, Adams GB (2018) Association between US state medical cannabis laws and opioid prescribing in the Medicare Part D population. *JAMA Internal Medicine.* 178(5):667–672. https://doi.org/10.1001/jamainternmed.2018.0266
[12] McMichael BJ, Van Horn RL, Viscusi WK (2020) The impact of cannabis access laws on opioid prescribing. Journal of Health Economics. 69:102273. https://doi.org/10.1016/j.jhealeco.2019.102273
[13] Bachhuber MA, Saloner B, Cunningham CO, Barry CL (2014) Medical cannabis laws and opioid analgesic overdose mortality in the United States, 1999-2010. *JAMA Internal Medicine*. 174(10):1668–1673. https://pubmed.ncbi.nlm.nih.gov/25154332/
[14] Smith RA (2020) The effects of medical marijuana dispensaries on adverse opioid outcomes. *Economic Inquiry*. 58(2):569–588. https://doi.org/10.1111/ecin.12825
[15] Powell D, Pacula RL, Jacobson M (2018) Do medical marijuana laws reduce addictions and deaths related to pain killers? Journal of Health Economics. 58:29–42. https://doi.org/10.1016/j.jhealeco.2017.12.007
[16] Shover CL, Davis CS, Gordon SC, Humphreys K (2019) Association between medical cannabis laws and opioid overdose mortality has reversed over time. Proceedings of the National Academy of Sciences. 116(26):12624–12626. https://doi.org/10.1073/pnas.1903434116
[17] Chan NW, Burkhardt J, Flyr M (2020) The effects of recreational marijuana legalization and dispensing on opioid mortality. *Economic Inquiry*. 58(2):589–606. https://onlinelibrary.wiley.com/doi/abs/10.1111/ecin.12819
[18] Chu Y-WL (2015) Do medical marijuana laws increase hard-drug use? The Journal of Law and Economics. 58(2):481–517. https://www.journals.uchicago.edu/doi/abs/10.1086/684043
[20] Doremus JM, Stith SS, Vigil JM (2019) Using recreational cannabis to treat insomnia: evidence from over-the-counter sleep aid sales in Colorado. *Complementary Therapies in Medicine.* 47:102207. https://doi.org/10.1016/j.ctim.2019.102207
[21] Sabia JJ, Dave D, Alotaibi F, Rees DI (2024) The effects of recreational marijuana laws on drug use and crime. *Journal of Public Economics*. 234:105075. https://doi.org/10.1016/j.jpubeco.2024.105075

	conditions as a result of cannabis substitution[19] • No impact on cocaine abuse treatment admissions[18]	
Mental health and workplace health	• Unclear whether it decreases or does not affect suicide rate[22, 23, 24] • Rise in work hours for adults over 51 with health conditions[25] • Reduced sick days[26] • Decreased workers' compensation claims by 6-7%[27]	• Increased applications for disability benefits[28]

How does cannabis legalization affect the economy?

The legal cannabis industry provided 440,445 full time jobs in U.S. by early 2024, with more than $28.8 billion in annual revenue.[29] These jobs are distributed in multiple sectors, ranging from cultivation (31%) to testing labs (<1%) (Figure 14). Cannabis sale is taxed at rates ranging from 10% in MI to 37% in WA.[30] MO's first year of recreational cannabis (RC) sales in 2023 boosted monthly revenues to over $110 million, compared to $38 million the previous year; which is driven by out-of-state consumers with stricter laws and higher taxes compared to MO's 6%.[29, 31] While RC sales in Missouri tripled, medical cannabis (MC) sales declined.[31] The state also recorded a 110% increase in cannabis related jobs, with employment increasing from 10,735 jobs in 2023 to 20,468 by March 2024.[29] Overall, more post-implementation data is needed to fully assess the public health and economic impact of recreational cannabis legalization, particularly in Missouri.

[19] Bradford AC, Bradford WD (2018) The impact of medical cannabis legalization on prescription medication use and costs under Medicare Part D. The Journal of Law and Economics. 61(3):461–487. https://www.journals.uchicago.edu/doi/abs/10.1086/699620
[22] Anderson DM, Rees DI, Sabia JJ (2014) Medical marijuana laws and suicides by gender and age. *American Journal of Public Health*. 104(12):2369–2376. https://doi.org/10.2105/AJPH.2013.301612
[23] Bartos BJ, Kubrin CE, Newark C, McCleary R (2020) Medical marijuana laws and suicide. *Archives of Suicide Research*. 24(2):204–217. https://doi.org/10.1080/13811118.2019.1612803
[24] Grucza RA, Hur M, Agrawal A, Krauss MJ, Plunk AD et al. (2015) A reexamination of medical marijuana policies in relation to suicide risk. *Drug and Alcohol Dependence*.152:68–72. https://doi.org/10.1016/j.drugalcdep.2015.04.014
[25] Nicholas LH, Maclean JC (2019) The effect of medical marijuana laws on the health and labor supply of older adults: Evidence from the health and retirement study. *Journal of Policy Analysis and Management*. 38(2):455–480. https://doi.org/10.1002/pam.22122
[26] Ullman DF (2017) The effect of medical marijuana on sickness absence. *Health Economics*. 26(10):1322–1327. https://doi.org/10.1002/hec.3390
[27] Ghimire KM, Maclean JC (2020) Medical marijuana and workers' compensation claiming. *Health economics*. 29(4):419–434. https://doi.org/10.1002/hec.3992
[28] Maclean JC, Ghimire KM, Nicholas LH (2021) Marijuana legalization and disability claiming. *Health economics*. 30(2):453–469. https://doi.org/10.1002/hec.4190
[29] Barcott B, Whitney B (2024) *Positive growth returns*. Jobs Report 2024. https://5711383.fs1.hubspotusercontent-na1.net/hubfs/5711383/VangstJobsReport2024-WEB-FINALFINAL.pdf
[30] Brown J, Cohen E, Felix RA (2023) Economic benefits and social costs of legalizing recreational marijuana. Federal Reserve Bank of Kansas City Working Paper. 2023:10–23. http://dx.doi.org/10.2139/ssrn.4590306
[31] Missouri Department of Health and Senior Services (DHSS) (2024) *Total Monthly, Quarterly, and Yearly Cumulative Marijuana Sales.* Data and Reports. https://health.mo.gov/safety/cannabis/img/cumulative-monthly-sales.jpg

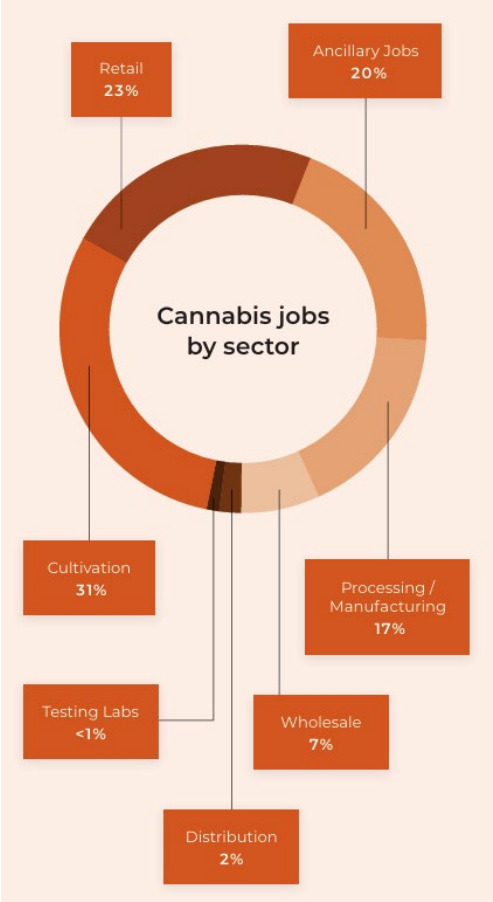

Figure 14. Breakdown of job sectors within the cannabis industry. Percentage of the total 440,445 cannabis-related jobs are shown for each sector.

What are the tobacco product taxes in other states?

Cigarettes are the most consumed tobacco product in the United States.[32] In addition to the federal tax of $1.01 per pack, each state has an excise tax on cigarettes, and some local governments levy a tax as well. Missouri has the lowest cigarette excise tax in the nation, at 17 cents per pack (Figure 15).[33]

Taxes on other tobacco products vary. Not every tobacco product is subject to an excise tax in each state. For example, FL and PA have no excise tax on cigars. Most states have a tax on e-cigarettes but 17 (including MO) do not.[34]

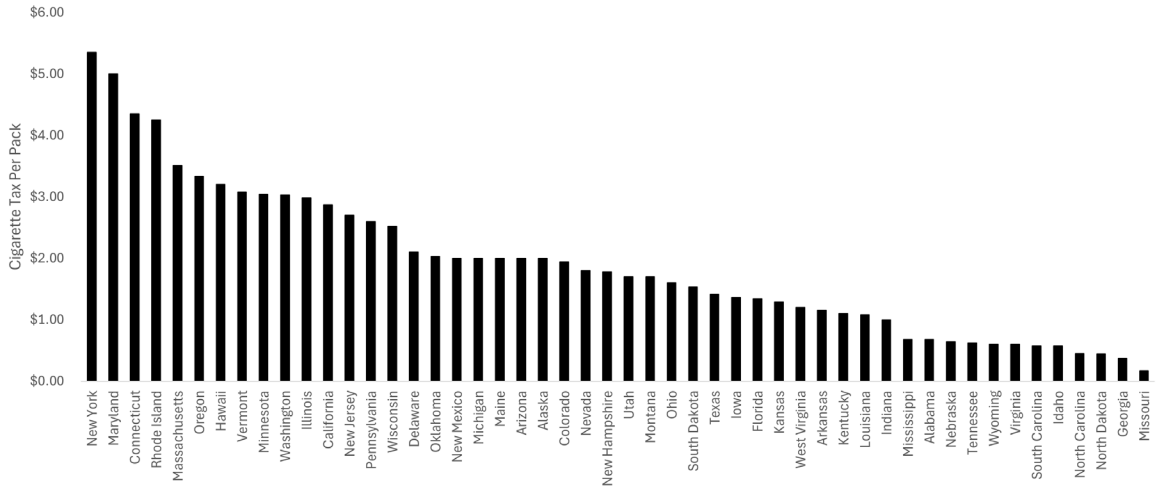

Figure 15. Cigarette excise taxes by state as of June 30, 2024. Data from the CDC State System Excise Tax Fact Sheet.

[32] Center for Disease Control (2024) *Tobacco Product Use Among Adults—United States, 2022.* Department of Health and Human Services. *https://www.cdc.gov/tobacco/media/pdfs/2024/09/cdc-osh-ncis-data-report-508.pdf*

[33] Center for Disease Control (2024) *STATE System Excise Tax Fact Sheet.* Department of Health and Human Services. https://www.cdc.gov/statesystem/factsheets/excisetax/ExciseTax.html

[34] Center for Disease Control (2024) *E-Cigarette Tax.* Department of Health and Human Services. https://www.cdc.gov/statesystem/factsheets/ecigarette/ECigTax.html

How is tobacco tax revenue used?

Missouri cigarette tax revenue is split between the State School Money Fund, the Health Initiatives Fund, and the Fair Share Fund.[35] Both the State School Money Fund and the Fair Share Fund go to education.[36] Approximately three quarters of the revenue from the cigarette tax goes to these two funds, with the remaining quarter going to the Health Initiatives Fund, part of which funds substance abuse programs.[37]

How do other states use revenue from taxes on tobacco products?

States use their cigarette tax revenue for a variety of purposes.[38] KS and AR use cigarette tax revenue as general revenue (GR). NE and KY allocate most but not all of their cigarette tax revenue to GR. NE directs a portion of cigarette tax revenue to several funds including capital projects and public safety communication.[39] IA directs its revenue to the Health Care Trust Fund. TN largely directs cigarette tax revenue to education. OK and IL direct their cigarette tax revenue to funds predominantly related to health and education.

Taxes on non-cigarette tobacco products are often allocated similarly to cigarette taxes. TN, AR, NE, and KS allocate these taxes to general revenue. MO, IL and IA allocate non-cigarette tobacco tax revenue to health-related funds, while TN allocates it to education.[38]

Metrics of success.

Tobacco taxes have dual goals of raising revenue and discouraging the use of tobacco products. Missouri raised $95 million in tobacco taxes in FY 2023.[40] Studies find that tobacco taxes discourage smoking.[41] Estimates of this impact vary, with studies since 2000 finding that a 10% price increase would reduce smoking by 1 to 3%. Taxes may reduce smoking more for youth and young adults.[42] Because smoking declines with income, these taxes place a relatively greater burden on low-income individuals.41 Taxes on one type of product may also impact consumption of other tobacco products. Taxes on e-cigarettes were found to reduce e-cigarette use and increase traditional cigarette use.[43]

Needle Exchange Programs

Needle exchange programs or syringe service programs (SSPs) offer free sterile syringes and safely collect and dispose of used ones to help prevent the spread of infections among people who use injection drugs. Comprehensive SSPs also offer services like counseling, infection testing, referral to substance abuse treatment, and other health services. [44, 45]

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[35] Rate of tax — how stamped — samples, how taxed — tax impact to be on consumer — fair share school fund, distribution. X (2006) REV MO § 149.015 https://revisor.mo.gov/main/OneSection.aspx?section=149.015

[36] Missouri State Treasurer *(*Sep 29 2023*) Fund Descriptions https://treasurer.mo.gov/content/about-the-office/1monthlyfundreports*

[37] Health initiatives fund established, use — Alt-care pilot program, components — participation may be required. XII (2023) REV MO § 191.831 https://revisor.mo.gov/main/OneSection.aspx?section=191.831

[38] American Lung Association. (July 29 2024) State Legislated Actions on Tobacco Issues (SLATI). https://www.lung.org/policy-advocacy/tobacco/slati/states

[39] *NE Code § 77-2602 (2023) https://nebraskalegislature.gov/laws/statutes.php?statute=77-2602*

[40] Missouri Department of Revenue. (2023) *Financial and Statistical Report. https://dor.mo.gov/revenue-annual-financial-report/documents/financialstatreport23.pdf#page=11*

[41] DeCicca P, Kenkel D, Lovenheim MF (2022) The Economics of Tobacco Regulation: A Comprehensive Review. *Journal of Economic Literature*. 60(3), 883–970. https://www.aeaweb.org/articles?id=10.1257/jel.20201482

[42] Bader P, Boisclair D, Ferrence, R. (2011) Effects of Tobacco Taxation and Pricing on Smoking Behavior in High Risk Populations: A Knowledge Synthesis*. International Journal of Environmental Research and Public Health. 8, 4118-4139.*

[43] Pesko MF, Courtemanche CJ, Maclean JC. (2020 The effects of traditional cigarette and e-cigarette tax rates on adult tobacco product use. *Journal of Risk and Uncertainty. 60: 229 https://doi.org/10.1007/s11166-020-09330-9 258*

[44]Center for Disease Control and Prevention (DCC) (2024) Syringe Services Programs. https://www.cdc.gov/syringe-services-programs/php/index.html

[45] Behrends CN, Lu X, Corry GJ, LaKosky P, Prohaska SM, Glick SN, Kapadia SN, et al. (2022) Harm reduction and health services provided by syringe services programs in 2019 and subsequent impact of COVID-19 on services in 2020. *Drug Alcohol Depend. 232:*109323. https://pubmed.ncbi.nlm.nih.gov/35124386/

What are the effects of SSPs?

SSPs not only reduce infection transmissions, but also have other reported benefits. SSPs are associated with a reduction in HIV cases.[46, 47, 48] After implementation, HIV transmission decreases by 10% in new HIV diagnoses.[49] Hepatitis C infections are also reduced by 50% when syringe access is combined with medications for opioid dependence.[50] Syringe sharing among injection drug users drops by 5-10% within six months, without increasing drug injection frequency.[51] Risk of infection to the public is also decreased as SSPs lower improper syringe disposal.[52, 53, 54, 55, 56] Participation in SSPs facilitates entry into substance use disorder treatment.[57, 58, 59] Many SSPs reduce drug overdoses by training individuals and distributing overdose prevention kits.[60, 61, 62, 63]

State policies governing SSPs.

As of 2021, SSPs were legal in 32 states and illegal in 11 states, including MO.[64] SSPs are also locally permitted, or authorized by local jurisdictions in 8 states (Figure 16). Federal funds from the U.S. Department of Health and

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[46] Aspinall EJ, Nambiar D, Goldberg DJ, Hickman M, Weir A, Van Velzen E, Palmateer N, Doyle JS, Hellard ME, Hutchinson SJ (2014) Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *Int J Epidemiol, 43*(1): 235-248. doi:10.1093/ije/dyt243. https://pubmed.ncbi.nlm.nih.gov/24374889/

[47] Fernandes RM, Cary M, Duarte G, Jesus G, Alarcão J, Torre C, Costa S, Costa J, Carneiro AV. (2017) Effectiveness of needle and syringe Programmes in people who inject drugs – An overview of systematic reviews. *BMC Public Health* 17, 309. https://doi.org/10.1186/s12889-017-4210-2

[48] Wodak A, Cooney A (2006) Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Substance Use Misuse. 41*(6–7):777–813. https://pubmed.ncbi.nlm.nih.gov/16809167/

[49] Packham A (2019) Are Syringe Exchange Programs Helpful or Harmful? New Evidence in the Wake of the Opioid Epidemic. NBER Working Paper Series, no. 26111. https://www.nber.org/papers/w26111

[50] Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, et al. (2017) Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database Syst Rev. 9*:CD012021. doi:10.1002/14651858.CD012021.pub2. https://pubmed.ncbi.nlm.nih.gov/28922449/

[51] DeSimone J (2005) Needle Exchange Programs and Drug Injection Behavior. *Journal of Policy Analysis and Management, 24*(3): 559-577. https://www.jstor.org/stable/30164064

[52] Levine, H., Bartholomew, T.S., Rea-Wilson, V., Onugha, J., Arriola, D.J., Cardenas, G., Forrest, D.W., Kral, A.H., Metsch, L.R., Spencer, E., Tookes, H. (2019) Syringe Disposal Among People Who Inject Drugs Before and After the Implementation of a Syringe Services Program. *Drug Alcohol Depend. 202*: 13-17. https://pubmed.ncbi.nlm.nih.gov/31280002/

[53] Tookes HE, Kral AH, Wenger LD, et al. (2012) A comparison of syringe disposal practices among injection drug users in a city with versus a city without needle and syringe programs. *Drug Alcohol Depend. 123*(1-3):255-259. doi:10.1016/j.drugalcdep.2011.12.001. https://pubmed.ncbi.nlm.nih.gov/22209091/

[54] Klein SJ, Candelas AR, Cooper JG, Badillo WE, Tesoriero JM, Battles HB, Plavin HA (2008) Increasing safe syringe collection sites in New York State. *Public Health Rep. 123*(4):433-440. doi:10.1177/003335490812300404. https://pubmed.ncbi.nlm.nih.gov/18763405/

[55] de Montigny L, Vernez Moudon A, Leigh B, Kim SY (2010) Assessing a drop box programme: a spatial analysis of discarded needles. *Int J Drug Policy. 21*(3): 208-214. doi:10.1016/j.drugpo.2009.07.003. https://pubmed.ncbi.nlm.nih.gov/19729291/

[56] Bluthenthal RN, Anderson R, Flynn NM, Kral AH (2007) Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program clients. *Drug Alcohol Depend. 89*(2-3):214-222. https://pubmed.ncbi.nlm.nih.gov/17280802/

[57] Jakubowski A, Fowler S, & Fox AD (2023). Three decades of research in substance use disorder treatment for syringe services program participants: a scoping review of the literature. *Addiction science & clinical practice*, *18*(1): 40. https://link.springer.com/content/pdf/10.1186/s13722-023-00394-x.pdf

[58] Strike C, Miskovic M. (2018) Scoping out the literature on mobile needle and syringe programs-review of service delivery and client characteristics, operation, utilization, referrals, and impact. *Harm Reduct J. 15*(1):6. https://pubmed.ncbi.nlm.nih.gov/29422042/

[59] Surratt HL, Otachi JK, Williams T, Gulley J, Lockard AS, Rains R (2020) Motivation to change and treatment participation among syringe service program utilizers in rural Kentucky. *The Journal of Rural Health, 36*(2):224-233. doi:10.1111/jrh.12388. https://pubmed.ncbi.nlm.nih.gov/31415716/

[60] Bennett AS, Bell A, Tomedi L, Hulsey EG, Kral AH (2011) Characteristics of an overdose prevention, response, and naloxone distribution program in Pittsburgh and Allegheny County, Pennsylvania. *J Urban Health. 88*(6): 1020-1030. doi:10.1007/s11524-011-9600-7. https://pubmed.ncbi.nlm.nih.gov/21773877/

[61] Galea S, Worthington N, Piper TM, Nandi VV, Curtis M, Rosenthal DM (2006) Provision of naloxone to injection drug users as an overdose prevention strategy: Early evidence from a pilot study in New York City. *Addict Behav. 31*(5): 907-912. doi:10.1016/j. addbeh.2005.07.020. https://www.sciencedirect.com/science/article/abs/pii/S0306460305002005

[62] Lambdin BH, Bluthenthal RN, Wenger LD, Wheeler E, Garner B, Lakosky P, et al. (2020) Overdose education and naloxone distribution within syringe service programs—United States, 2019. *MMWR Morb Mortal Wkly Rep.* 69(33):1117–21. https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a2.htm

[63] Seal KH, Thawley R, Gee L (2005) Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: A pilot intervention study. *J Urban Health. 82*(2):303–311. doi:10.1093/jurban/jti053. https://pubmed.ncbi.nlm.nih.gov/15872192/

[64] amfAR (2021) Syringe Exchange Program Legality (2021). Accessed Nov 2024 https://opioid.amfar.org/indicator/SSP_legality

Human Services may support SSPs but cannot be used to purchase syringes.[65] The CDC recommends a low-threshold access to services, such as maximizing number of locations and hours, keeping participants' confidentiality, no requirements to engage in additional services, and providing syringes based on expressed need.[66] Identification and registration requirements may inhibit use of services, and one-to-one exchange, or allowing participants only the same number of syringes returned, increases sharing of used syringes and discourages distribution of cleaned ones to others in need.[66, 67, 68]

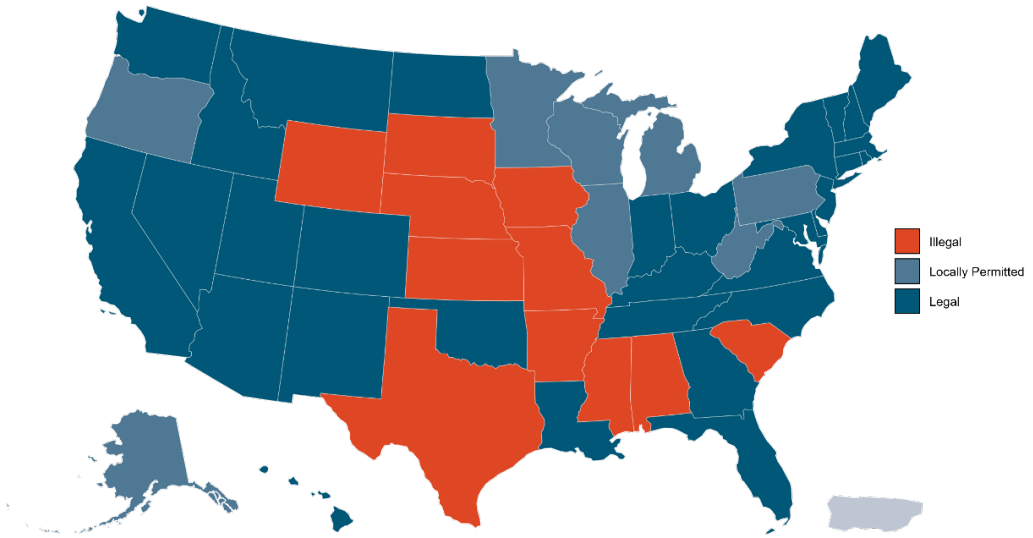

Figure 16. States that have authorized syringe exchange programs by 2021.[64]

The following summary is based on the Legislative Analysis and Public Policy Association's compilation of policies on SSPs:[69]

Policy	Number of States	States
Registration with the SSP required	7	DE, ME, MD, NJ, NM, NY, RI
ID requirements for participants, volunteers, or staff	8	CT, DE, ME, MD, NJ, NM, NY, OH
Traceable syringes	4 + DC	DE, MD, VA, WV
One-to-One exchange requirement	6	DE, FL, HI, ME, NM, WV
Unlimited syringes allowed	7	AZ, GA, IL, NC, TN, UT, VA
Additional supplies including cookers, tourniquets, cotton swabs, alcohol, and sharps disposal containers authorized	14	AZ, GA, IL, MD, NC, ND, NH, NM, NV, RI, TN, UT, VA, WV
Law enforcement engagement required	10	CA, CO, GA, ME, NC, OH, RI, TN, UT, VA

[65] U.S. Department of Health and Human Services (HHS) (2016) SSP Implementation Guidance 2016. https://www.cdc.gov/syringe-services-programs/media/pdfs/2024/04/hhs-ssp-guidance.pdf

[66] Javed Z, Burk K, Facente S, Pegram L, Ali A, Asher A (2020) Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation, Center for Disease Control and Prevention 9. https://www.cdc.gov/overdose-prevention/media/pdfs/Syringe-Services-Programs-SSPs.pdf

[67] Kerr T, Small W, Buchner C, Zhang R, Li K, Montaner J, Wood E (2010) Syringe sharing and HIV incidence among injection drug users and increased access to sterile syringes. *American journal of public Health, 100*(8):1449-53. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2009.178467

[68] Lorvick J, Bluthenthal R, Scott A, Lou Gilbert M, Riehman KS, Anderson RL, Flynn NM, Kral AH (2006) Secondary syringe exchange among users of 23 California syringe exchange programs. *Substance Use Misuse,41*(6-7): 865-882. https://doi.org/10.1080/10826080600669041

[69] Legislative Analysis and Public Policy Association (2023) Syringe services programs: Summary of state laws. https://legislativeanalysis.org/wp-content/uploads/2023/11/Syringe-Services-Programs-Summary-of-State-Laws.pdf

Syringes as drug paraphernalia exceptions for SSPs	22	CA, CO, DE, FL, IL, IN, IA, KY, LA, MD, MI, MT, NM, NC, ND, OH, OK, TN, UT, VT, VA, WA + DC, PR

How is the success of SSPs measured?

Evaluation of success involves tracking the numbers of needles exchanged, the cleanliness of needles in circulation, the rates of HIV and other needle-borne diseases, referrals to drug treatment programs, enrollments in those programs, and changes in the risky behaviors of participants.[70]

To see hyperlinks and appendices, please visit https://house.mo.gov/CommitteeReports.aspx.

The following members' presence was noted: Appelbaum, Aune, Banderman, Boggs, Bosley, Ealy, Farnan, Hovis, Jones (12), Meirath, Parker, Proudie, Sharp (37), Thompson, West, and Whaley.

ADJOURNMENT

On motion of Representative Riley, the House adjourned until 4:00 p.m., Monday, February 3, 2025.

CORRECTION TO THE HOUSE JOURNAL

HOUSE JOURNAL CORRECTION AFFIDAVIT

I, State Representative Mark Sharp, District 37, hereby state and affirm that my presence should have been noted in the Journal of the House for Wednesday, January 29, 2025 on Page 460, Line 41. Pursuant to House Rule 93, I am requesting that the Journal be corrected to show that I was in fact present in the chamber and my presence should have been recorded.

IN WITNESS THEREOF, I have hereunto subscribed my hand to this affidavit on this 30th day of January, 2025.

/s/ Mark Sharp
State Representative

State of Missouri)
) ss.
County of Cole)

Subscribed and sworn before me this 30th of January in the year 2025.

/s/ Sandra Kay Pinet
Notary Public

[70] National Research Council (US) and Institute of Medicine (US) Panel on Needle Exchange and Bleach Distribution Programs; Normand J, Vlahov D, Moses LE, editors. Preventing HIV Transmission: The Role of Sterile Needles and Bleach. Washington (DC): National Academies Press (US); 1995. 7, The Effects of Needle Exchange Programs. Available from: https://www.ncbi.nlm.nih.gov/books/NBK232343/

COMMITTEE HEARINGS

AGRICULTURE
Tuesday, February 4, 2025, 8:00 AM, House Hearing Room 7.
Public hearing will be held: HB 1116
Executive session will be held: HB 544

BUDGET
Monday, February 3, 2025, 12:00 PM, House Hearing Room 3.
Budget presentations from the Office of Administration and departments: Coronavirus State Fiscal Recovery Fund – ARPA (HB 20), reappropriations (HB 17), maintenance and repair (HB 18), capital improvements (HB 19), Office of Administration (HB 5), employee benefits (HB 5), and real estate (HB 13). No public testimony will be taken.

CHILDREN AND FAMILIES
Tuesday, February 4, 2025, 8:00 AM, House Hearing Room 6.
Public hearing will be held: HB 121, HB 236, HB 219
Executive session will be held: HB 339, HB 243, HB 280

CHILDREN AND FAMILIES
Tuesday, February 4, 2025, 4:00 PM, House Hearing Room 1.
Public hearing will be held: HJR 54

ECONOMIC DEVELOPMENT
Tuesday, February 4, 2025, 8:00 AM, House Hearing Room 1.
Public hearing will be held: HB 325
Executive session will be held: HB 269

ELECTIONS
Tuesday, February 4, 2025, 8:00 AM, House Hearing Room 5.
Public hearing will be held: HB 575, HB 551
Executive session will be held: HJR 23, HJR 3

ELEMENTARY AND SECONDARY EDUCATION
Wednesday, February 5, 2025, 12:00 PM or upon adjournment (whichever is later), House Hearing Room 7.
Public hearing will be held: HB 31, HB 712, HB 854, HB 408, HB 306
Executive session will be held: HB 538, HB 711

EMERGING ISSUES
Monday, February 3, 2025, 4:30 PM or upon adjournment (whichever is later), House Hearing Room 7.
Public hearing will be held: HB 35, HB 1016, HB 1038, HB 1081, HB 36, HB 113, HB 624, HB 135
Executive session will be held: HB 875, HB 970

HEALTH AND MENTAL HEALTH
Monday, February 3, 2025, 10:00 AM, House Hearing Room 7.
Presentation by court-appointed public administrators to discuss case examples that have led to issues regarding mental health.

HEALTH AND MENTAL HEALTH
Tuesday, February 4, 2025, 12:00 PM, House Hearing Room 6.
Public hearing will be held: HB 195, HB 1119, HB 825, HB 822
Executive session will be held: HB 943, HB 177, HB 469

INSURANCE
Monday, February 3, 2025, 1:00 PM, House Hearing Room 6.
Public hearing will be held: HB 618

JOINT COMMITTEE ON TRANSPORTATION OVERSIGHT
Thursday, February 13, 2025, 8:00 AM, Joint Hearing Room (117).
MoDOT's presentation of annual report.
Pending applications for memorial highway and bridge designations.
Pending applications for specialty license plates.

LOCAL GOVERNMENT
Wednesday, February 5, 2025, 8:00 AM, House Hearing Room 5.
Public hearing will be held: HB 923, HB 200
Executive session will be held: HB 148, HB 352

SPECIAL COMMITTEE ON INTERGOVERNMENTAL AFFAIRS
Monday, February 3, 2025, 4:30 PM or upon adjournment (whichever is later),
House Hearing Room 6.
Public hearing will be held: HB 290, HB 607, HB 778

TRANSPORTATION
Tuesday, February 4, 2025, 4:30 PM or upon adjournment (whichever is later),
House Hearing Room 7.
Public hearing will be held: HB 296, HB 438, HB 378

VETERANS AND ARMED FORCES
Monday, February 3, 2025, 4:30 PM or upon adjournment (whichever is later),
House Hearing Room 1.
Public hearing will be held: HB 714
Executive session will be held: HB 262, HB 419
Presentations by Jon Sabala, Veterans Services Director with the Missouri Department of Mental Health, and Troy Williams, Chairman of Missouri Association of Veterans Organizations (MAVO).
Added HB 714.
AMENDED

WAYS AND MEANS
Monday, February 3, 2025, 4:30 PM or upon adjournment (whichever is later), House Hearing Room 5.
Public hearing will be held: HB 517, HB 708
Executive session will be held: HB 349, HB 660, HB 816, HJR 4

HOUSE CALENDAR

FIFTEENTH DAY, MONDAY, FEBRUARY 3, 2025

HOUSE JOINT RESOLUTIONS FOR SECOND READING

HJR 79 and HJR 80

HOUSE BILLS FOR SECOND READING

HB 1130 through HB 1153

HOUSE RESOLUTIONS

HCS HR 141 - Roberts

ACTIONS PURSUANT TO ARTICLE IV, SECTION 27

SS SCS HCS HB 2002 - Deaton
SS SCS HCS HB 2003 - Deaton
SS SCS HCS HB 2004 - Deaton
SS SCS HCS HB 2005 - Deaton
SS SCS HCS HB 2006 - Deaton
SS SCS HCS HB 2007 - Deaton
SS SCS HCS HB 2008 - Deaton
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