



Opioid Use Disorder as a
Public Health Crisis
April 21, 2026

Agenda

Overview

-Legislation and Context

Methodology & Observations

Primary Goal

Overview

Overview and Background

- PA 25-168 declared opioid use disorder a “public health crisis” until goals defined by an ADPC workgroup are met.
- Unlike the federal “public health emergency” designation, under state law, “public health crisis” has no definition, does not include funding, and does not waive or expedite any regulations to help address the “crisis”.
- Goals must be reported to the Public Health Committee by July 1, 2026.

Statutory Language

§§174–175 of PA 25–168 (HB 7287)

Sec. 174. (NEW) (*Effective from passage*): It is hereby declared that opioid use disorder constitutes a public health crisis in this state and will continue to constitute a public health crisis until each goal reported by the Connecticut Alcohol and Drug Policy Council pursuant to subsection (f) of section 17a–667a of the general statutes is attained.

Sec. 175. Section 17a–667a of the general statutes is amended by adding subsection (f) as follows (*Effective from passage*): (NEW) (f) The Connecticut Alcohol and Drug Policy Council shall convene a working group to establish one or more goals for the state to achieve in its efforts to combat the prevalence of opioid use disorder in the state. Not later than July 1, 2026, the council shall report, in accordance with the provisions of section 11–4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding each goal established by the working group.

Methodology & Observations

Methodology

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
# of Accidental Intoxication Deaths	256	291	321	326	323	311	287	324	358	495	568	729	917	1038	1017	1200	1374	1524	1452	1328	982
Opioid in Any Death	234	265	293	297	295	284	262	296	327	419	513	663	861	961	948	1127	1273	1413	1339	1216	845
% Intoxication Deaths with Opioid	91%	91%	91%	91%	91%	91%	91%	91%	91%	85%	90%	91%	94%	93%	93%	94%	93%	93%	92%	92%	86%
% Change Year over Year		14%	10%	2%	-1%	-4%	-8%	13%	10%	38%	15%	28%	26%	13%	-2%	18%	15%	11%	-5%	-9%	-26%

Methodology: OCME did not start tracking opioids specifically in accidental intoxication deaths until 2013. To obtain an approximate number for 2004 through 2013, DMHAS calculated the average percent of deaths with opioids from 2013 to 2024 (91%) and applied this to the total number of accidental intoxication deaths from 2004 to 2014. Numbers in **bolded red** are based on these assumptions.

Observations

2004–2010	2011–2012	2013–2016	2017–2021	2022–2024
PRE-CRISIS BASELINE	TRANSITION PERIOD	ABNORMAL ACCELERATION	ELEVATED PLATEAU & SECOND SURGE	DECLINE, BUT STILL ELEVATED
• Values range from 234–297 • Some year-to-year movement, but no sustained acceleration (in fact, deaths decline from 2007 to 2010)	• From 2011 to 2012, there was about a 10% increase • Still within historical range, but upward pressure starts • Early signs of increase appear, but not yet crisis-level	• Multiple consecutive years of 20–30% growth • Beginning around 2013, opioid-involved deaths entered a period of rapid and sustained acceleration, marking the onset of the crisis phase.	• High death rate, but volatile • Another sharp rise during COVID years • Peak in 2021 at 1,413	• Declines are meaningful, especially 2024 • However, still well above any pre-crisis level

While opioid-involved deaths in Connecticut fluctuated between 2004 and 2010 without sustained growth, **beginning in 2013 the state experienced a marked and persistent acceleration.** This period represents a clear departure from prior trends.

Primary Goal

Recommendation for Calculation

- *Baseline:* Average of 2004–2010 – 276 deaths a year
- *Rationale:* The 2004–2010 period represents the last sustained era of relative stability, prior to the onset of abnormal growth in opioid-involved mortality. Using this period as a baseline reflects conditions before the crisis-driven acceleration began
- Current mortality remains multiple times higher than baseline levels

Primary Goal

- **Reduce opioid-involved deaths to the pre-crisis baseline (276 deaths a year) and sustain that level for a minimum of five consecutive years.**
- By reversing the post-2011 acceleration in opioid-involved mortality, the state will work toward reducing annual opioid-involved deaths to the average level observed during the 2004–2010 pre-crisis period and maintaining that level, or lower, for at least five consecutive years.

Why Does Maintenance Matter?

- The goal emphasizes not only reaching the baseline but sustaining it over multiple years
- Short-term declines in opioid-involved deaths can result from temporary factors, including fluctuations in the drug supply or reporting variability
- Sustained maintenance of baseline levels over a defined period indicates that underlying systems are functioning effectively and durably
 - Examples of underlying systems: prevention, treatment, harm reduction, and recovery supports

Why Five Years?

- Provides sufficient time to distinguish lasting progress from short-term variation
- Also aligns with planning and evaluation cycles commonly used in public health and allows for assessment across multiple cohorts, funding cycles, and policy implementations



The use of a pre-crisis baseline as a goal does not imply that any level of opioid-involved death is acceptable, nor does it diminish the importance of continued prevention efforts beyond that point.

Next Steps

Stakeholder Feedback

- Tested by statistical/data experts in the field
- Review of goal from the Co-Chairs of ADPC subcommittees
- **Review from the Alcohol and Drug Policy Council (today)**
- Approval by OPM/OTG in submitted report
 - Report is due July 1, 2026
 - Aim to get to OPM beginning of June for review, edits, and approval

Input/Feedback

- What questions do you have about the presented goal or the methodology?
- What context would be helpful to add in a final report?
 - Example: state by state comparison; overview of current resources (triennial report, e.g.)
- Is there any other feedback you want considered?

Thank You!

Any questions?