Virginia's Opioid Settlements

The United States is in the **midst of a crisis** on its streets and in its communities as **overdoses, homelessness, and disorder reach record levels**. Yet settlement proceeds secured by the Commonwealth of Virginia present an **unprecedented opportunity for generational investment** in treatment capacity for chronic substance abuse (CSA) and severe mental illness (SMI).

Virginia is set to receive **more than $1.1 million** (*$1,126,715,700.47*) in opioid settlement funds—more than one-third of the commonwealth's share of the monumental Tobacco Master Settlement Agreement.[1] With twenty-one settlements and payments spread out over decades, the funds are **at risk of being squandered** through ad-hoc allocations to **diffuse and disorganized efforts**.

The commonwealth must ensure that this opportunity for treatment investment is not underutilized. **Virginia can make targeted investments in treatment capacity** that will **honor those who suffered** in the opioid crisis and **ensure accessible care** for decades to come.

Virginia functionally allocates funds by reserving 23.25 percent (*$264,667,058.82*) for use by the commonwealth and its agencies, 57.5 percent for use by subdivisions, and the remaining 19.25 percent is to be further allocated by the 11-person Virginia Opioid Abatement Authority to the commonwealth or subdivisions.[2] [i] [ii] Of the commonwealth's share, 15 percent of total funds is technically allocable by the legislature from the Commonwealth Opioid Abatement and Remediation Fund, while the remaining 8.25 percent of total funds is allocable by the Authority to state agencies from the Opioid Abatement Fund.[3] [4]

The latest report shows the Authority allocated nearly $20 million to state agencies over the past few years, with $600,000 to public defenders and $1.3 million to harm reduction sites indicating a diffuse focus, though these are two among dozens of other projects.[5] The legislature allocated nearly $36

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[i] Virginia initially allocates 15 percent of funds for the commonwealth's use, 15 percent to an unrestricted subdivision fund, 15 percent to a restricted subdivision fund, and 55 percent to the abatement fund. The monies in the abatement fund are allocated as follows: 15 percent (8.25 percent of total funds) is for use by state agencies, 15 percent (8.25 percent of total funds) is allocated to subdivisions, 35 percent (19.25 percent of total funds) is for use by regional partnerships comprised of at least two subdivisions, and the remaining 35 percent (19.25 percent of total funds) is for use by the Virginia Opioid Abatement Authority for further allocations to the prior recipients.

[ii] With the exception of the McKinsey and Publicis settlements, in which the commonwealth controls 100 percent of funds.

million to just four agencies in the same period, including $4 million for a state opioid data system and $2 million for a jail-based CSA treatment and transition fund.

The legislature and the Authority must exercise greater discretion and prioritize investments in comprehensive treatment networks. **Three priorities** (certified community behavioral health clinics, secure psychiatric beds, and community SMI/CSA response) **will ensure these funds have the largest impact** on Virginia.

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs, designed to ensure access to coordinated comprehensive behavioral health care, have stable funding and are supported by all recent presidential administrations. CCBHCs are a key response to the opioid crisis and can augment other services such as police crisis response teams, homelessness outreach and services, and outpatient psychiatric commitment services.

- **Solution: Fund the development and expansion of CCBHCs.**
    - Expand the CCBHC footprint with an emphasis on a team-based approach to co-occurring disorders.
    - Create a stepped approach to SMI/CSA treatment with services provided by the CCBHCs.
    - Require CCBHCs to offer specific care pathways to meet the needs of individuals with co-occurring disorders.

State Psychiatric Hospitals

Inpatient beds in secure facilities are critical for serving the highest-acuity psychiatric patients. Virginia currently has only **5.2 state psychiatric beds** per 100,000 people for civil (i.e., non-criminal) patients.[6] [7] Treatment Advocacy Center recommends a rate of 30-60 beds per 100,000. Even counting non-public secure psychiatric beds, Virginia still falls short of the minimum.[8] Secure beds are a costly but necessary expenditure to protect patients with severe psychiatric disorders and the public at large.

- **Solution: Fund the expansion of civil psychiatric beds.**
    - Invest in expanding state hospital capacity.
    - Move forensic (criminal) commitments to a jail-based restoration facility.
    - Apply for one of several Section 1115(a) waivers to expand Medicaid reimbursement for institutions for mental diseases (IMDs).

Inpatient Stabilization Centers and Mobile Crisis Teams

Emergency departments (EDs) are supposed to be a last resort for times of true emergencies, but are increasingly used for all types of immediate-need medical care. This is especially true for low- to medium-acuity mental health crises. In order for CCBHCs and state psychiatric bed expansions to have the largest impact, there must be an immediate triage of low-acuity patients from higher-need patients, or else investments in these facilities will be drowned out, overburdened, and underutilized by those that need them most, just like emergency departments.

- **Solution: Fund community-based mental health response resources.**
    - Expand community-based recovery centers, including voluntary short-term respite housing, especially for young adults.
    - Leverage CCBHC resources to develop comprehensive mobile crisis response teams in conjunction with police crisis intervention teams (CIT).
    - Support integration of community resources with crisis networks such as the Lifeline to support those in need or provide guidance for concerned loved ones.

[1] KFF. "Actual Tobacco Settlement Payments Received by the States (in millions)." Accessed 8 September 2025. https://www.kff.org/health-costs/state-indicator/tobacco-settlement-payments.
[2] "Virginia Opioid Abatement and Settlement Allocation Memorandum of Understanding." https://drive.google.com/file/d/1KYpZWpUhs0S4HEC-jvLIdmWoyP04Y9dE/view?usp=sharing.
[3] Code of Virginia § 2.2-2377. Commonwealth Opioid Abatement and Remediation Fund. https://law.lis.virginia.gov/vacode/title2.2/chapter22/section2.2-2377/.
[4] Code of Virginia § 2.2-2374. Opioid Abatement Fund. https://law.lis.virginia.gov/vacode/title2.2/chapter22/section2.2-2374/.
[5] Virginia Opioid Abatement Authority, "2024 Annual Report." https://rga.lis.virginia.gov/Published/2025/RD26/PDF.
[6] Treatment Advocacy Center, "Virginia Psychiatric Beds Report." 2023. https://www.tac.org/wp-content/uploads/2023/10/Virginiabedsinformation.pdf.
[7] United States Census Bureau, "2023 American Community Survey – Total Population." https://data.census.gov/table/ACSDT1Y2023.B01003?q=population&t=Population+Total&g=010XX00US$0400000.
[8] Silver, Shanti, "Estimating Psychiatric Bed Need in the United States," p. 2-4. Treatment Advocacy Center Office of Research and Public Affairs. January 2024. https://www.tac.org/wp-content/uploads/2024/03/TAC_ORPA_ResearchSummary1.24.pdf.