AGENDA

Eau Claire County
Opioid Settlement Task Force
Tuesday, January 17, 2023, at 5:30 p.m.
Eau Claire County Government Center
721 Oxford Ave., Eau Claire • Room 3312

Join from the meeting link:

https://eauclairecounty.webex.com/eauclairecounty/j.php?MTID=m14e9a66663ca4d2c14bde8025fc05519

Join by meeting number:

Meeting number: 2590 390 2733 Password: v2xQ2CEnF3p

Join by phone:

Dial in: 415-655-0001 Access Code: 2590 390 2733

1. Call to Order and confirmation of meeting notice
2. Roll call
3. Public Comment
4. Review of Opioid White Paper – **Discussion**
5. Approved Opioid Abatement Language – **Information/Discussion**
6. February Meeting Date – **Discussion**
7. Adjourn

Prepared by: Samantha Kraegenbrink – Assistant to the County Administrator

PLEASE NOTE: Upon reasonable notice, efforts will be made to accommodate the needs of individuals with disabilities through sign language, interpreters, remote access, or other auxiliary aids. Contact the clerk of the committee or Administration for assistance (715-839-5106). For additional information on ADA requests, contact the County ADA Coordinator at 839-6945, (FAX) 839-1669 or 839-4735, TTY: use Relay (711) or by writing to the ADA Coordinator, Human Resources, Eau Claire County Courthouse, 721 Oxford Avenue, Eau Claire, WI 54703.

Recommendations for Use of National Prescription Opioid Litigation Settlement Funds

Eau Claire County Opioid Task Force
May 2022

Introduction

On January 28, 2022, Eau Claire County Administrator Kathryn Schauf formed the Eau Claire County Opioid Task Force (Task Force) in response to the settlement reached in the National Prescription Opiate Litigation. Membership of the Task Force included individuals from public health, human services, law enforcement, criminal justice, and veterans' services departments. The Task Force was charged with engaging in cross-functional discussion regarding the current state of the opioid crisis in the County to identify gaps in programming and funding and develop recommended uses for the expected funding Eau Claire County will receive as part of the settlement.

Background

While a full recitation of the history of opioids in the U.S. is outside of the scope of this paper, a brief overview is in order to provide a general idea of the scale of the issue.

Opioids are a particular class of both prescription and illegal street drugs. Prescription opioids, like oxycodone, hydrocodone, morphine and others, when prescribed and used correctly can effectively relieve pain (United States Department of Health and Human Services [HHS], n.d.-a). Incorrect use or prescription opioids or use of illegal opioids such as heroin or fentanyl creates a risk of dependence and addiction. The United States has a long, winding history with opioid use, both licit and illicit, stretching back to the late 1800s (National Association of County & City Health Officials [NACCHO], 2019). Opioids and other pain-reduction remedies were widely unregulated until Congressional action in 1914 (Jones et al., 2018). This action was prompted by increased presence of illicit opiates on the streets and growing concern with opioid dependency. The result of the legislation was a general aversion to opiates by prescribers and patients alike for most of the 20th century. The late 1990s, however, saw a resurgence in opioid pharmaceutical products and their prescription. Increased availability of new prescription opioids, coupled with misinformation about their addictive nature perpetuated by the pharmaceutical companies, lead to significant over-prescription (NACCHO, 2019).

Since 1999, overdose deaths involving prescription opioids has increased six-times (NACCHO, 2019).

The U.S. government officially declared the opioid epidemic a public health emergency on October 16, 2017 (Jones et al., 2018). Despite the declaration, the opioid epidemic is still raging. More than 70,000 people died from drug overdose in 2019 and 1.6 million people reported having an opioid use disorder in 2019 (HHS, n.d.-b).

In light of the dramatic, irreparable harm caused by the misinformation and recklessness of pharmaceutical manufacturers and distributors with prescription opioids, various civil lawsuits were filed by the federal, state, and local governments against opioid distributors and manufacturers (Addiction Center, n.d.). The most sweeping of the lawsuits, and perhaps the largest ever civil law lawsuit in U.S. history, is *In re: National Prescription Opiate Litigation*, Case No. MDL 2804. The National Prescription Opiate Litigation is a consolidation of more than 2,000 opioid-related lawsuits that were filed in various U.S. courts (Dwyer, 2019). On July 21, 2021, a settlement agreement was announced to resolve the vast majority of the lawsuits under the National Prescription Opiate Litigation.

In response to the settlement reached under National Prescription Opiate Litigation, 2021 Wisconsin Act 57[1] was enacted, establishing Wis. Stat. § 165.12 which governs how the funds from the settlement are used by the state and local governments. In relevant part, Wis. Stat. § 165.12 sets forth the following requirements for local governments receiving settlement funds:

- All funds must be deposited into a segregated account and may not be comingled with any other funds.
- Funds may only be used for approved opioid abatement purposes as identified in the settlement agreement or other court order.
- Funds may not be used to substitute for budgeted funds from other sources.
- Funds may be pooled between other local governments if each local government complies with these and other reporting requirements.
- Local governments must submit a report to the Wisconsin Department of Justice and Joint Committee on Finance by May 1 of each year. The report must include the amount of the money in the segregated account as of December 31 of the previous year and an accounting of the receipts and disbursements from the segregated account.

2021 Wisconsin Act 57 mandates 30% of the total settlement proceeds as payable to the State. The remaining 70% of the total settlement proceeds are payable to the local governments that are parties to the litigation. The Eau Claire County Board of Supervisors, having previously joined the litigation, voted to enter into a proposed settlement of the litigation in December 2021 making Eau Claire County eligible for a share of the 70% allocation. In total, Eau Claire County is expected to receive approximately $3.3 million dollars over 18 years as part of the settlement. After applicable attorney and other court ordered fees are assessed, Eau Claire County will receive

[1] For a detailed explanation of 2021 Wisconsin Act 57, see the Wisconsin Legislative Council Act Memo.

approximately $2.5 million dollars, or approximately $137,000 each year, for 18 years for opioid abatement purposes.

Recommendations

In coming to the recommendations that follow, the Task Force met seven times between February and May 2022. The Task Force reviewed various publications that outline best practices for opioid treatment and abatement (*See,* e.g., Carroll, Green, & Noonan, 2018; NACCHO, 2019) and relied on the collective knowledge and expertise of the Task Force members.

The Task Force recommends using settlement funds to support the following projects and programs:

A. Medication-Assisted Treatment (MAT) support in the Eau Claire County Jail with a focus on MAT maintenance while incarcerated.
    a. Deemed one of the most effective therapies for opioid dependence by the World Health Organization (2004), MAT provides patients with FDA approved medication that has been proven to assist patients with opioid withdrawal symptoms. MAT is administered by qualified healthcare professionals. By establishing a MAT maintenance program in the Eau Claire County Jail, individuals experiencing periods of incarceration will be able to continue to receive the needed medication to help them lead a normal life.

B. Sober living opportunities in the community including increasing available in-patient bed space and peer support.
    a. A key to maintaining sobriety is surrounding oneself with a community of likeminded individuals and stable housing. Increasing sober living opportunities and support networks within them is one way to assist individuals who are on the path of recovery from opioid use disorder.

C. Peer support programs, with funding specifically used to deploy peer support after periods of incarceration or hospitalization.
    a. The bedrock of successful re-entry into the community after individuals experience periods of incarceration or hospitalization is a support network. By expanding accessibility of community-based peer support programs that are available prior to re-entry, individuals can have an established support network in place and ready to help them get back to normal life.

D. Naloxone supply and distribution, including additional or total allocation of naloxone based on jurisdiction or organization.

    a. Naloxone (better known by the brand name Narcan) is a fast acting opioid antagonist that can safely reverse the oftentimes fatal effects of an opioid overdose. By ensuring first responders, community agencies, organizations, and citizens have access to and education about the proper administration of naloxone, opioid overdose fatalities can be reduced.

E. Licit and illicit opioid disposal options in the community including bags, receptacles, needles, needle collection.

    a. Reducing the overall amount of opioids in the community is essential to begin addressing the root of the opioid crisis. Providing no-questions-asked disposal options for both licit and illicit opioids and related paraphernalia is one way to begin the reduction of overall quantity. Individuals can simply place unused or unwanted opioids in receptacles that are routinely emptied.

F. AODA assessment services for individuals experiencing a period of incarceration in the Eau Claire County Jail.

    a. In order to begin the journey to recovery from not only opioid use disorder but other substance use disorders is understanding the scope and scale of the needs of the individual. By expanding AODA assessment services in the Eau Claire County Jail, individuals will be more likely to receive the targeted care and treatment that will best addresses their particular needs.

G. Opioid Treatment funds (program and R&B) for uninsured or underinsured persons.

    a. Removing financial access barrier for residents that are uninsured and/or underinsured is a way to provide timely treatment to an individual that might otherwise forgo treatment. Eligible residents must have an opioid dependency diagnosis, poly substance dependency diagnosis, or documented opioid use history.

The Task Force further recommends the following:

A. Public input sessions for settlement fund use.

B. Transparent annual review of settlement uses, availability, and best practices.

C. Formation of a continued planning and oversight group for the duration of the settlement fund use period.

The foregoing recommendations should be considered as a starting point and adjustments may be necessary as final settlement amounts are determined and additional statutory and administrative rules may be promulgated. Initial program area budgets are attached as Appendix A. In coming to the funding figures, there is still uncertainty about the full cost of each program as the Task Force was unable to fully flesh costs and had to rely on best-estimate costs and they are still being collected.

Conclusion

While the settlement funds Eau Claire County, and the rest of the nation, is to receive from the National Prescription Opiate Litigation pales in comparison to the incredible amount of money and resources already expended to respond to the opioid crisis, the additional funding to support expansion and creation of new evidence-based programs is welcome. This initial work of the Eau Claire County Opioid Task Force is just the beginning on the long road to remedying the lasting and devastating effects of the opioid epidemic. Though the task ahead is daunting, the Task Force expressed great hope and commitment to serving all Eau Claire County residents affected by the opioid epidemic.

Appendix A – Budget

Program	Description(s)		Annual Cost
A. MAT support – Eau Claire County Jail - focused on MAT maintenance while incarcerated.			$ 23,674.00
Calculation/Estimate: Jail is working with a contractor.			
B. Sober Living –bed increases, peer support.			$ 22,500.00
Calculation/Estimate: EC Sober living sponsorship 1500/mo x 15 mo			
C. Peer Support Programs – funding could be used to deploy peer support after incarceration or hospitalization.			$ 24,960.00
Calculation/Estimate: Certfied Peer Support Specialist 60$/hr x 416 hours			
D. Narcan Supply/Distribution – to include additional or total allocation of Narcan based on jurisdiction or organization.			$ 18,750.00
Calculation/Estimate: $75 per unit (2 doses/unit); 250 units =	18750		
E. Illicit and licit opioid disposal – bags, receptacles, needles, needle collection.			$ 31,140.00
Calculation/Estimate:	6 community needle disposal bins + monthly pick-up =	19160	
	300 lock boxes (32.95/ea) and 100 lock bags (20.95/ea)=	11980	
F. AODA Assessment Services in the county jail environment.			$ 11,440.00
Calculation/Estimate:	$55/hr* 208		
G. Opioid Treatment funds (program and R&B) for uninsured or underinsured persons.			$ 13,200.00
Calculation/Estimate: 30 residential days @ $339/day program max + $101/Day R&B max			
			$ 145,664.00

References

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Dwyer, C. (2019, October 15). *Your guide to the massive (and massively complex) opioid litigation.* NPR. https://www.npr.org/sections/health-shots/2019/10/15/761537367/your-guide-to-the-massive-and-massively-complex-opioid-litigation

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National Association of County & City Health Officials. (2019, May). *Local opioid overdose prevention and response: A primer for local health departments.*

World Health Organization. (2004). *WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention.* apps.who.int/iris/bitstream/10665/42848/1/9241591153_eng.pdf?ua=1

United States Department of Health and Human Services. (n.d.-a) *What are opioids?* https://www.hhs.gov/opioids/prevention/index.html

United States Department of Health and Human Services. (n.d.-b) *What is the U.S. opioid epidemic?* https://www.hhs.gov/opioids/about-the-epidemic/index.html

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

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

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

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

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

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

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

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

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

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

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

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

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

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

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

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

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

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

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

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

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.