REPORT OF THE CHIEF LEGISLATIVE ANALYST

DATE: October 30, 2023

TO: Honorable Members of the Housing Committee

FROM: Sharon M. Tso
Chief Legislative Analyst

Council File No: 23-0670
Assignment No: 23-06-0355

Opioid Settlement and Tobacco Settlement Funds

SUMMARY

During the 2023-24 Budget deliberations, Council approved the transfer of $11.8M for Substance Use Disorder Treatment Beds and $11.7M in Opioid Settlement funds from General City Purposes (GCP), to be administered by the Mayor, to the Unappropriated Balance (UB), pending additional information from the Mayor as to how funding will be spent. On June 20, 2023, the Mayor reported with a proposal for spending both sources of funds for a total expenditure of approximately $23.5M. The proposed program would fund longer substance use disorder treatment cycles for unhoused residents after their Los Angeles County-authorized stays have ended.

On June 28, 2023, Council approved the transfer of approximately $3.9M from Substance Use Disorder Treatment Beds and approximately $3.9M from Opioid Settlement funds, for a total of $7.8M, a portion of the originally requested funding amount of $23.5M, from the UB to GCP, for the Mayor's proposed program. At that time, Council instructed the Mayor to report with a detailed plan for the expenditure of the funds as well as an annual projection of anticipated receipts form both the Tobacco and Opioid Settlements and likelihood of future impact to the General Fund. Council further instructed the Chief Legislative Analyst and City Administrative Officer (CAO) to report with recommendations for policies and programs that could be eligible for the Tobacco and Opioid Settlement funds. The CAO's input has been incorporated into this report.

Tobacco Settlement Funds

The CAO reports that Tobacco Settlement revenue is part of a settlement in which seven tobacco companies agreed to restrictions on marketing practices and to pay $206 billion during a 25-year period through 2025 to California, 45 other states, the District of Columbia and five U.S. territories. This agreement has since been extended indefinitely. In 2000, the State first received California's share of the settlement, estimated to be more than $900 million annually. Half of the payment goes to California's General Fund. The remainder is divided based on population, among California's 58 counties and four largest cities for use as decided by each local government. Major factors for changes to the amount that the City receives each year include the volume of cigarettes shipped, prices, and the relative population of California counties.

The CAO further notes that Tobacco Settlement revenue has always been considered a General Fund receipt with no restrictions on the use of the funds. The City received approximately $10.7M in 2022-23. The Adopted Budget estimates that the City will receive $10.7M in 2023-24. he UB line item entitled Substance Abuse Beds has been allocated $11.8M in the 2023-24

Adopted Budget. Although it has been reported that the Tobacco Settlement funding is directly related to the Substance Use Disorder Beds line item, the line item is funded by the General Fund and is not directly related to a single funding source.

Opioid Settlement Funds

The City filed suit against Purdue Pharma L.P. and other opioid manufacturers, distributors and retailers on May 3, 2018 (*City of Los Angeles v. Purdue Pharma L.P.*). On March 15, 2019, the City amended the complaint to include additional defendants, such as retailers. The City's complaint was eventually consolidated for pre-trial proceedings with over 2,000 other opioid actions filed on behalf of municipalities around the country. The consolidated litigation is known as the National Prescription Opiate Multi District Litigation (MDL).

After three years of litigation and negotiations, representatives of the State Attorneys General, and the Plaintiffs' Executive Committee in the MDL reached national agreements with the "Big Three" opioid distributors, Amerisource Bergen, Cardinal Health and McKesson (Distributors), and with opioid manufacturers, Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc. and Janssen Pharmaceutica, Inc. (Johnson & Johnson). In 2021, Council approved the City's participation in the Distributors and Johnson & Johnson settlements. It is estimated that the City will receive from $29.6 million to $53.3 million for these two settlements over a period of 18 years.

In March 2023, Council approved settlements with five major retailers: Teva Pharmaceutical Industries Ltd and Teva Pharmaceuticals USA, Inc., Allergan Finance, LLC and Allergan Limited, Walmart Inc., Walgreen Co., and CVS Health Corporation and CVS Pharmacy, Inc. These settlements are national settlements, available to all litigating municipalities, including the City. They are payable over a number of years with a total maximum national value of $18.52 billion. The ultimate settlement value will depend on the number of states and municipalities that subscribe to the settlement. The structure of the settlement makes it difficult to determine exactly how much the City will receive, but the total maximum value, number of years payable, and estimated minimum and maximum settlement proceeds for the City are as follows:

Settlement	Years	Total Maximum Value	City's Minimum Proceeds	City's Maximum Proceeds
Teva	13	$3.34B	$3.75M	$8.33M
Allergan	7	$2.02B	$2.22M	$4.94M
Walmart	6	$2.74B	$2.43M	$6.39M
Walgreens	15	$5.52B	$5.02M	$12.25M
CVS	10	$4.90B	$4.28M	$11.27M
Total:		**$18.52B**	**$17.70M**	**$43.18M**

In addition to the significant settlements listed above, the City Attorney has reported that settlements with various entities currently involved in bankruptcy proceedings may provide additional funding for the City as they are approved. Similarly to the opioid settlements with the manufacturers, distributors and retailers, the City Attorney notes that the specific amount that the City will receive is difficult to determine at this time.

The City must use approximately 80 percent of the settlement funds for future opioid remediation. The City can use the remaining 20 percent either for future opioid-related projects or to reimburse the City's General Fund for past opioid-related expenses (ex: for the purchase of

Narcan, or for training first responders on the use of Narcan). Allowable expenditures for cities and counties receiving settlement funds for opioid remediation must include activities related to the ending, reducing, or lessening the effects of the opioid epidemic in communities, and include prevention, intervention, harm reduction, treatment, and recovery services.

The California Department of Health Care Services organized the allowable uses for the California Opioid Settlements funds into two sections: High Impact Abatement Areas (HIAA), and Core Strategies and Approved Uses.

High Impact Abatement Areas (HIAA)
Cities and Counties must use at least 50 percent of the funds in each calendar year for one or more of the High Impact Abatement Activities shown in Table 1.

Table 1: High Impact Abatement Activities

No.	Activity
1	Provision of matching funds or operating costs for substance use disorder (SUD) facilities with an approved project within the Behavioral Health Continuum Infrastructure Program
2	Creating new or expanded SUD treatment infrastructure
3	Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD
4	Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction
5	Interventions to prevent drug addiction in vulnerable youth
6	The purchase of naloxone for distribution and efforts to expand access to naloxone for opioid overdose reversals.

Core Strategies and Approved Uses
The California Department of Health Care Services urges cities and counties to give priority to the listed core abatement strategies provided in Schedule A of their 'List of Opioid Remediation Uses' (Attachment 1: Exhibit E of the national settlement agreements):

A. Naloxone or Other FDA-Approved Drug to Reverse Opioid Overdoses
B. Medication-Assisted Treatment (MAT) Distribution and Other Opioid-Related Treatment
C. Pregnant and Postpartum Women
D. Expanding Treatment for Neonatal Abstinence Syndrome (NAS)
E. Expansion of Warm Hand-Off Programs and Recovery Services
F. Treatment for Incarcerated Population
G. Prevention Programs
H. Expanding Syringe Service Programs
I. Evidence-Based Data Collection and Research Analyzing the Effectiveness of the Abatement Strategies within the State

Existing City Opioid/Substance Abuse Programs
The Department on Disability offers a number of substance use treatment, harm reduction, and education programs through its AIDS Coordinator's Office, including the Syringe Collection

Program, substance use treatment referrals, opioid overdose prevention training, behavioral health counseling, and health education programs. The Department currently has contracts with the following organizations that offer a variety of different services:

1. Asian American Drug Abuse Program, Inc.
2. Being Alive
3. Bienestar Human Services, Inc.
4. Clean Needles Now
5. Homeless Health Care Los Angeles
6. HOPICS
7. Sidewalk Project
8. Tarzana Treatment Center
9. Venice Family Clinic

Many of these organizations serve the unhoused population and provide wraparound services, connecting individuals to medical care and housing opportunities. They are spread out across all 15 Council Districts, with some offering pop up services in high need areas like Skid Row. The Department is pursuing new opportunities to expand programs and services such as drug testing, as fentanyl-related overdoses continue to rise in the City.

In addition to the Department on Disability programs, the City has designated funding within the Consolidated Plan and to the Housing Department, in its contracts with the Los Angeles Homeless Services Authority (LAHSA),0. for homeless services, including drug treatment options.

Approved and Pending Actions
On April 19, 2023, Council approved an instruction to request that the City Attorney provide a biannual report on the proceeds received and how funding has been expended from the opioid litigation (C.F. 21-1240-S2).

On June 7, 2023, the Neighborhoods and Community Enrichment Committee approved the Motion (Hernandez – Yaroslavsky) to transfer $1.5 million from the Opioid Settlement Funds to a Council District 1 MacArthur Park Harm Reduction Center (C.F. 23-0600-S32). The Motion is currently pending in the Budget, Finance and Innovation Committee.

Council Policy Considerations and Recommendations
In summary, the CAO reports that Tobacco Settlement Funds, which the City has received since 2000, are treated as General Fund each year and are expended as part of the entire General Fund pool. These funds, as well as any sources considered to be part of the General Fund, could be directed to specific substance abuse prevention programs, or any other related services, including anti-harm kits, education programs and other services, should the Council decide to do so as part of the City's annual budget process.

Opioid Settlement funds are a new source of funds that the City began receiving in early 2023. They can generally be used for a variety of uses including training on the use and distribution of Naxalone; assisting individuals with the cost of substance treatment programs; expanding education for first responders, youth, pregnant and post-partum women and new mothers; expansion of existing recovery services; treatment for incarcerated individuals; prevention programs and expansion of syringe service programs. As these settlement funds and the

programs they will fund are new to the City, the Council may want to consider determining the use of the funds outside of the City's annual budget process.

Aside from existing programs within the Department on Disability, the City has not yet created a program to prevent or treat substance abuse. As these programs will be newly created or expanded, there will likely be savings available. As the programs are developed, the most restricted funding (Opioid Settlement) should be spent prior to the Tobacco Settlement funds, which are less restricted in terms of expenditure guidelines. Any unspent Tobacco Settlement funds should revert to the Reserve Fund at the end of the fiscal year. In addition, with savings available, the Council District One request for $1.5M for the MacArthur Park Harm Reduction Center should be considered for funding. No other requests for current-year funds have been made at this time.

For future years, it is recommended that the CAO be instructed to perform an annual review of the previous years' use of Opioid Settlement funds, report with the amount of funds the City has received (or will receive) for the following year, and consult with each Council Office to determine the expenditure of funds. This will allow Council to annually review the results of the previous years' funded programs and determine the appropriate use of funds for the following year. It is further recommended that this office and the CAO consult with the City Attorney prior to recommending expenditures of Opioid Settlement funds to ensure compliance with expenditure guidelines.

RECOMMENDATIONS

That the Council:

1. Instruct the CAO to report prior to September 1 annually with the amount of Opioid Settlement funding received and available for programming, at which time, the CAO can seek proposals from Council Districts on expenditures; and

3. Instruct the CLA and CAO to consult with the City Attorney prior to proposing expenditures of any Opioid Settlement funding to ensure the allowable use of funds under the opioid settlement agreements.

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Attachment 1: Exhibit E: Final Settlement Agreement - List of Opioid Remediation Uses

California Department of Health Care Services: California Opioid Settlements Allowable Expenditures

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*").[1]

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.

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[1] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indication 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 cooccurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health (MH) 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 evidenceinformed programs or strategies that may include, but are not limited to, those that:[2]

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 cooccurring 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 evidencebased 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.

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

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

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. Dissemination 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 cooccurring 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 cooccurring 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

cooccurring 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 cooccurring 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 cooccurring 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 cooccurring 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 cooccurring 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 cooccurring 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.