CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS
Sitting/Acting as Board of Health

Policy Session Worksheet

Presentation Date: March 5, 2024 **Approx. Start Time:** 11:30am **Approx. Length:** 30 min

Presentation Title: Opioid Settlement Funding Recommendations for Eligibility & Solicitation Process

Department: Health, Housing & Human Services (H3S)

Presenters: Rodney Cook, H3S Director, and Denise Swanson, Deputy H3S Director

WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?

To review the criteria and process the Board of County Commissioners (BCC) would like followed for opioid settlement funding proposals from community partners.

EXECUTIVE SUMMARY:

During the Board of County Commissioner's (BCC) Policy Session on January 10, 2024, the BCC instructed H3S staff to formalize the criteria and process for soliciting funding proposals from community partners for County Opioid Settlement Funds. This document provides H3S staff recommendations for funding allocations and the recommended process to coordinate funding proposals from community partners. H3S staff have consulted with the County Finance Department who will help determine the final procurement or grants management process.

Issue #1 - Proposed Funding Allocations

Given the future prospects of a Clackamas County recovery center and potential extension of currently funded programming, H3S staff recommend that the BCC consider a fiscally conservative approach that includes the following allocations for the next year only with current funding available ($1,966,221.91). If approved, this allocation of funding would be for this funding only and staff would return at a future date to ask the BCC to allocate future funds as they become available.

- Up to $1,000,000 of Opioid Settlement Funding be allocated for community partners to apply through a competitive application process.
    - Applications from community partners are suggested to be limited to $200,000 per application period.
    - Applicants already receiving opioid settlement funds directly from the State of Oregon may apply for County Opioid Settlement Funding to assist in expanding substance use prevention efforts and must demonstrate a cash match within their application.
- Up to $750,000 of Opioid Settlement Funding revenue be set aside for implementation of BCC and County priority projects, which may increase continuation of existing programming.
- Up to $215,000 of Opioid Settlement Funding revenue be allocated for H3S staff to coordinate application process, contract administration, data analysis, evaluation, and reporting.

Issue #2 - Recommended Process and Application Criteria

H3S staff recommend a process to assure an accessible, fair, and transparent process for community partners to apply for County Opioid Settlement Funds. This includes an application for external partners to submit proposals that, with support from PGA, will be available on the County's website.

County staff will review proposals using the below criteria and bring forward for the BCC's final review and approval.

Proposed Criteria

- Program strategy/services must align with and support the Clackamas County resolution setting forth the framework for a recovery-oriented system of care (see attachment #1)
- Program strategy/services must fill an urgent gap or critical need in addressing issues related to substance use in Clackamas County (see attachment #2).
- All program strategy/services must use evidenced based principles and be listed as an approved Opioid abatement strategy, as listed in Exhibit E (see attachment #3).
- Program strategy/services must demonstrate some level of integration of the continuum of services that include elements of prevention, treatment, recovery, and intervention with justice involved individuals.
- Proposals must include evaluation metrics, such as numbers to be served/impacted, target success rate data, etc.
- Programs providing strategy/services to geographic areas that have not received other Opioid Settlement funds will receive high priority.
- Proposals are limited to a 2-year period of funding (itemized budget for each year is required) with the County option to approve future extensions if outcomes are being met and funding allows.

FINANCIAL IMPLICATIONS (current year and ongoing):

Is this item in your current budget? ☐ YES ☒NO

What is the cost? Clackamas County expects to receive $24,726,052 in Opioid Settlement Funds over a 17-year period. There is currently $1,966,221.91 in funds available for this funding cycle.

What is the funding source? Opioid Settlement Funds. *There is a requirement to spend funding allocations within 5 years, ensuring entities act promptly to address the opioid crisis.

STRATEGIC PLAN ALIGNMENT:

- **How does this item align with your Department's Strategic Business Plan goals?**
  Improve community safety & health

- **How does this item align with the County's Performance Clackamas goals?**

  This effort aligns with the Performance Clackamas goal to *Ensure Safe, Healthy and Secure Communities*, by addressing the social determinants of health including: addiction, homelessness, lowering crime, employment, and links to critical behavioral health services.

  .

  Clackamas County's Opioid Settlement Framework aligns with the goal, to *Build Public Trust through Good Government*, by embedding community engagement, transparency, and accountability in all processes.

LEGAL/POLICY REQUIREMENTS:

In the National Settlement Agreement, local governments commit to use all funds for future opioid abatement per Exhibit E of the national settlement agreements ("Approved Abatement Uses").

PUBLIC/GOVERNMENTAL PARTICIPATION:

The Clackamas County Opioid Settlement Framework approved by the BCC in September of 2022 includes Community Engagement as a key area to ensure fair and transparent funding distribution based on the John Hopkins University framework.

OPTIONS:

1. Approve as presented. Staff will return with funding recommendations, up to $1,000,000, from community partners for BCC review and approval.
2. Approve with modifications.
3. Provide alternative options for staff and instruct them to come back at a later date.

RECOMMENDATION:

Staff respectfully recommends Option #1, approve as presented. Staff will return with funding recommendations, up to $1,000,000, from community partners for BCC review and approval.

ATTACHMENTS:

- Attachment 1 – Clackamas County Recovery-Oriented System of Care Resolution
- Attachment 2 - High level findings from opioid settlement listening sessions
- Attachment 3 - Exhibit E Allowable Use of Opioid Settlement Funds

SUBMITTED BY:

Division Director/Head Approval _____
Department Director/Head Approval Rodney A. Cook
County Administrator Approval _____

For information on this issue or copies of attachments, please contact Philip Mason-Joyner @ 503-742-5956

BEFORE THE BOARD OF COUNTY COMMISSIONERS

OF CLACKAMAS COUNTY, STATE OF OREGON

In the Matter of Supporting a Recovery-Oriented System of Care in Responding to the Addictions, Mental Health and Homelessness Crisis

Resolution No. 2023-043

WHEREAS, Clackamas County has identified drugs, crime, and untreated mental illness, of which homeless encampments are a symptom, as top threats to the health, safety and flourishing of all of its residents; and

WHEREAS, Clackamas County believes in the dignity and worth of its residents, and the communal good that is achieved when residents are on a path toward the realization of their full potential; and

WHEREAS, Clackamas County acknowledges that a significant and consequential portion of both those struggling with homelessness in the greater Portland area and throughout North America also contend with the complex diseases of mental illness and or addiction, whether a precursor to or a result of homelessness; and

WHEREAS, the U.S. Surgeon General specifically describes addiction as a brain disorder disease that results in reduced brain function, that inhibits an individual's ability to make decisions and regulate his or her actions, emotions, and impulses, and furthermore, that changes in the brain persist long after substance use stops and recognizes that addiction to alcohol or drugs is a chronic brain disease that has the potential for recurrence and recovery; and

WHEREAS, Clackamas County recognizes that housing alone cannot cure mental illness or addiction, and the nature of addiction and serious mental illness can make sufferers unable to recognize their own illnesses or seek help willingly and benefit from a well-coordinated continuum of care to help them get the supports they need; and

WHEREAS, Clackamas County agrees that open air drug scenes create violence that is incompatible with clean and vibrant public spaces, and make recovery from addiction more difficult; and

WHEREAS, Clackamas County believes that harm reduction services, when not antithetical to a recovery-oriented system of care, can be effective in saving lives. Moreover, they must exist within a full continuum of compassionate care that includes prevention, intervention, treatment, and recovery for those suffering from addiction; and

WHEREAS, Clackamas County identifies other contributing factors to homelessness, including domestic violence, experience in the child welfare system, economic and health crises, and physical and mental health conditions and is identifying strategies to address these factors; and

BEFORE THE BOARD OF COUNTY COMMISSIONERS

OF CLACKAMAS COUNTY, STATE OF OREGON

In the Matter of Supporting a Recovery-Oriented System of Care in Responding to the Addictions, Mental Health and Homelessness Crisis	}	Resolution No. 2023-043 *Page 2 of 2*

WHEREAS, Clackamas County believes that all people have a right to clean and vibrant public spaces, as well as safe emergency and transitional shelter when needed;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF CLACKAMAS COUNTY that all efforts to address homelessness in which the County and its employees engage must be concentrated on helping all residents participate in realizing their full human potential, by ensuring shelter, psychiatric, behavioral health and addiction care for all who need it, and by protecting public spaces for the use of the entire community.

DATED this 6th day of April, 2023

BOARD OF COUNTY COMMISSIONERS

Chair

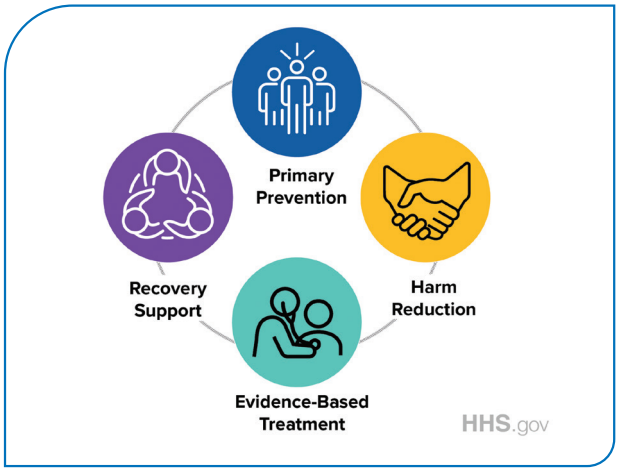
Recording Secretary

Strategies to confront the opioid crisis in Clackamas County

Overview of gaps and priorities

Clackamas County is expected to receive $13.7 million over the next 18 years, as stipulated by a settlement agreement with pharmaceutical companies for their actions that helped fuel the opioid crisis.

Community perspectives from nearly 60 local organizations serving Clackamas County were gathered to identify current service gaps and prioritize approved abatement strategies to inform settlement allocation decisions. Common themes of existing gaps in accessing services include workforce and transportation challenges, as well as a lack of culturally responsive services. Participants also identified the following:



Recovery Support

Current Gaps

- Overnight shelters, supportive and long-term housing and access to low-income permanent housing that embraces a harm reduction model
- Peer recovery mentors and community-based recovery centers
- Childcare and transportation, particularly in rural communities

Priority Strategies

- Invest in additional housing supports that integrate MOUD and other supportive services
- Expand access to peer recovery centers that may include support groups, social events, computer access, and other services
- Provide additional resources and assistance to help with basic needs (childcare; transportation)

Substance Use Prevention

Current Gaps

- Early childhood skills-building and education specific to fentanyl and overdose prevention.
- School-based interventions, including mentorship programs, school resource officers, drug/alcohol counselors and community parenting classes
- Incomplete local data due to inconsistent in Student Health Survey participation
- Limited rural resources, lack of mental health interventions and few service providers accepting Oregon Health Plan coverage

Priority Strategies

- Expand school-based interventions to prevent opioid use
- Remove barriers to access for youth mental health services
- Provide additional evidence-based prevention programming (parental skills, child life skills, family communication, case management)

Harm Reduction

Current Gaps

- Reliable availability and access to naloxone across all populations, particularly for rural communities, youth and non-English speakers
- Mobile harm reduction services currently unable serve the entire county
- Fentanyl-related education for the community, DHS, and law enforcement.

Priority Strategies

- Increase distribution of naloxone and improved access for priority populations
- Provide additional community harm reduction trainings and messaging to decrease stigma related to naloxone and MOUD.
- Expand mobile unit resources that offer or provide referrals to harm reduction services available in all communities throughout the county

Linkage to Treatment

Current Gaps

- Limited availability among existing services, including medications for opioid use disorder (MOUD)
- Trauma-informed transitions from the hospital, emergency departments and urgent care settings.
- Education for health care providers on trauma-informed care and reducing stigma
- Adequate and sustainable funding

Priority Strategies

- Increase access to emergency department interventions that include MOUD, peer support, discharge planning, and recovery case management or supportive services.
- Expansion of warm hand-off programs (Project Hope, Behavioral Health and First Responder co-response)

Evidence Based Treatment

Current Gaps

- Limited availability of community triage and stabilization centers that include peer support, detox, and referrals to services
- Methadone providers and same-day access to medications
- MOUD services for youth, rural communities, and sustainable programming in jails
- Services with immediate access to treatment, including high barriers for:
  - Youth
  - People with co-occurring SUD and mental illness
  - People not criminal justice-involved
  - Fathers with children
  - People insured through OHP

Priority Strategies

- Increase inpatient/residential treatments and MOUD community resources in community (health systems, mobile units, justice settings)
- Provide additional access to evidence-based withdrawal management services
- Support crisis stabilization centers that serve as an alternative to EDs for persons with substance use disorders, co-occurring mental health conditions, and those who experience an overdose

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.