THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

Contract Number

SAP Number

CAO – Finance and Administration

Department Contract Representative	
Telephone Number	
Contractor	City of Rialto
Contractor Representative	
Telephone Number	
Contract Term	
Original Contract Amount	
Amendment Amount	
Total Contract Amount	
Cost Center	

This Agreement for the Use of the Local Allocation of California Opioid Settlement Funds ("Agreement") is made and entered into on the date this Agreement is fully executed by and between SAN BERNARDINO COUNTY ("County") and CITY OF RIALTO ("City"). City and County may be referred to individually as "Party" and or collectively as "Parties."

WHEREAS, the United States is facing an ongoing public health crisis of opioid abuse, addiction, overdose, and death. The State of California and California counties and cities have spent and continue to spend millions of dollars each year to address the direct consequences of this crisis; and

WHEREAS, in response to the opioid crisis, counties, cities, and states across the country filed lawsuits to hold opioid manufacturers, distributors, pharmacies, and others responsible for the harms caused by their deception, negligence, and creation of a public nuisance; and

WHEREAS, on or about July 19, 2018, the County filed a lawsuit in the United States District Court for the Central District of California against numerous opioid manufacturers and distributors alleging that as a result of the unlawful conduct of the defendants, the opioid crisis resulted, which caused damage to the County and its residents; and

WHEREAS, the County's lawsuit was transferred to the United States District Court for the Northern District of Ohio to become part of the multidistrict litigation ("MDL"), consisting of thousands of lawsuits brought by various states and local subdivisions, including counties, cities, and special districts, against a number of opioid distributors and manufacturers; and

WHEREAS, on or about, July 21, 2021, distributors McKesson Corporation, Cardinal Health, Inc., and AmerisourceBergen Corporation (collectively, "Distributors"), and manufacturers Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc. (collectively, "Janssen") tentatively reached two separate settlements (hereinafter referred to as the "Distributor Settlement Agreement" and "Janssen Settlement Agreement," respectively) in the MDL, which allow for participation by eligible non-litigating Local Subdivisions; and

WHEREAS, City is an eligible non-litigating Local Subdivision and has submitted the requisite documentation necessary to participate in the Distributor and Janssen settlements;

WHEREAS, under the Distributor and Janssen Settlement Agreements, the states and their Local Subdivisions may enter into allocation agreements to govern how the settlements funds from the two settlements coming to a state will be allocated to the state and its Local Subdivisions; and

WHEREAS, the State of California ("State") and its Local Subdivisions have entered into Allocation Agreements for both the Distributor and Janssen settlements, which provide that each eligible Local Subdivision that participates in the settlements will have its Local Allocation go to the county where the subdivision is located, unless the Local Subdivision notifies the Settlement Fund Administrator, at least 60 days before each payment date, that it elects to take a direct distribution of its Local Allocation; and

WHEREAS, the City has decided it will not take a direct distribution of its Local Allocation, and will instead have its Local Allocation distributed to the County; and

WHEREAS, the parties wish to set forth the terms as to the County's use of the City's Local Allocation; and

NOW, THEREFORE, in consideration of the preceding recitals, together with the mutual covenants hereinafter contained, the parties hereto mutually agree that the above recitals are true and correct and incorporated into the terms of this Agreement and as follows:

A. DEFINITIONS

a. *CA Abatement Accounts Fund* shall mean "CA Abatement Accounts Fund" as defined in the Allocation Agreements.

b. *Allocation Agreement(s)* means the allocation agreements entered into by and between the State and its Local Subdivisions specifying how the settlement funds from the Distributor and Janssen settlements will be distributed to the State and its Local Subdivisions. These agreements are entitled, "Proposed California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds – Distributor Settlement" and "Proposed California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds – Janssen Settlement."

c. *DHCS* is the California Department of Health Care Services.

d. *Local Allocation* means a Local Subdivision's share of the settlement funds from the Distributor and Janssen settlements, as set forth in Appendix 1 to the Allocation Agreements.

e. *Local Subdivision(s)* means cities and counties.

f. *Master Agreements* shall refer to the Distributor Settlement Agreement and the Janssen Settlement Agreement.

g. *Settlement Fund Administrator* shall mean the "Settlement Fund Administrator" as defined in the Master Agreements.

B. SCOPE

a. This Agreement supplements and is subject to the terms of the Master Agreements and the Allocation Agreements and any amendments thereto. If any term of this Agreement is inconsistent with a mandatory term of the Master Agreements or the Allocation Agreements, the order of the governing document shall be as follows: Master Agreements, Allocation Agreements, and last, this Agreement.

b. This Agreement governs the County's use of the City's Local Allocation paid directly to the County.

C. USE OF CITY'S LOCAL ALLOCATION

a. Participation

I. City shall have all of its Local Allocation paid directly to the County.

II. City shall not, at any time, advise the Settlement Fund Administrator that it requests direct payment of its Local Allocation.

III. The parties understand that the Local Allocation is payable over an approximate 18 year period. The parties further understand that the yearly disbursement amount of the Local Allocation payment may vary.

b. County's Use of the City's Local Allocation

I. The City's Local Allocation will become part of the County's share of the CA Abatement Accounts Fund, which will be:

1. Used by County in accordance with Section 4.B.ii (Use of CA Abatement Account Funds) of the Allocation Agreements; and
2. Reported on by County in accordance with Section 4.B.iii (CA Abatement Accounts Fund Oversight) of the Allocation Agreements.

II. The parties understand and agree that the City's Local Allocation that will be distributed to the County may only be used by County for future opioid remediation as described in Exhibit E to the Master Agreements, attached hereto as **Attachment I**.

III. The parties also understand and agree that no less than 50% of the CA Abatement Accounts Fund in each calendar year will be used for one or more of the following High Impact Abatement Activities:

1. The provision of matching funds or operating costs for substance use disorder facilities within the Behavioral Health Continuum Infrastructure Program;

2. Creating new or expanded Substance Use Disorder ("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; and/or

5. Interventions to prevent drug addiction in vulnerable youth.

IV. County understands and agrees that it is responsible for the reporting requirements to DHCS as specified in Section 5 of the Allocation Agreements.

V. County understands and agrees that it is responsible for responding to any DHCS oversight inquiries and/or requests as specified in Section 4.B.iii. of the Allocation Agreements.

VI. County will track all deposits and expenditures of CA Abatement Accounts Funds consistent with Section 5(c) of the Allocation Agreements.

D. GENERAL CONTRACT REQUIREMENTS

D.1 Recitals

The recitals set forth above are true and correct and incorporated herein by this reference.

D.2 Assignability

Neither party may assign this Agreement without the prior written consent of the other party.

D.3 Attorney's Fees and Costs

If any legal action is instituted to enforce any party's rights hereunder, each party shall bear its own costs and attorney fees, regardless of who is the prevailing party.

D.4 Choice of Law

This Agreement shall be governed by and construed according to the laws of the State of California.

D.5 Legality and Severability

The parties' actions under the Agreement shall comply with all applicable laws, rules, regulations, court orders and governmental agency orders. The provisions of this Agreement are specifically made severable. If a provision of the Agreement is terminated or held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall remain in full effect.

D.6 Mutual Covenants

The parties to this Agreement mutually covenant to perform all of their obligations hereunder, to exercise all discretion and rights granted hereunder, and to give all consents in a reasonable manner consistent with the standards of "good faith" and "fair dealing".

D.7 Relationship of the Parties

Nothing contained in this Agreement shall be construed as creating a joint venture, or partnership, between the Parties hereto, nor shall either Party have the right, power or authority to create an obligation or duty, expressed or implied, on behalf of the other Party hereto.

D.8 Termination for Convenience

Except as otherwise specified in this provision, the County and the City each reserve the right to terminate the Agreement, for any reason, with a thirty (30) day written notice of termination. In the event of termination of this Agreement, the City shall not be entitled to any of the City's Local Allocation that (1) had already been distributed to the County prior to the effective date of termination, or (2) is scheduled to be distributed to the County within 60 days of the notice of termination.

D.9 Notice

All written notices provided for in this Agreement or which either party desires to give to the other shall be deemed fully given, when made in writing and either served personally, or deposited in the United States mail, postage prepaid, and addressed to the other party as follows:

To County: To City:

County Administrative Office – Finance & Administration
Matthew Erickson, Chief Financial Officer
385 N. Arrowhead Ave. 4th Floor
San Bernardino, CA 92415-0123

Notice shall be deemed communicated two (2) County working days from the time of mailing if mailed as provided in this paragraph.

D.10 Venue

The parties acknowledge and agree that this Agreement was entered into and intended to be performed in San Bernardino County, California. The parties agree that the venue of any action or claim brought by any party to this Agreement will be the Superior Court of California, San Bernardino County, San Bernardino District. Each party hereby waives any law or rule of the court, which would allow them to request or demand a change of venue. If any action or claim concerning this Agreement is brought by any third party and filed in another venue, the parties hereto agree to use their best efforts to obtain a change of venue to the Superior Court of California, San Bernardino County, San Bernardino District.

D.11 Informal Dispute Resolution

In the event of any dispute, claim, question or disagreement arising from or relating to this Agreement or breach thereof, the parties hereto shall use their best efforts to settle the dispute, claim, question or disagreement. To this effect, they shall consult and negotiate with each other in good faith and, recognizing their mutual interests, attempt to reach a just and equitable solution satisfactory to both parties.

E. TERM OF AGREEMENT

This Agreement is effective as of the date fully executed and expires following the final settlement payout, but may be terminated earlier in accordance with the provisions of this Agreement.

F. INDEMNFICATION

F.1 County agrees to indemnify, defend (with counsel reasonably approved by City) and hold harmless City and its officers, employees, agents, and volunteers from any and all claims, actions or losses, damages, and/or liability resulting from County's negligent acts or omissions which arise from County's performance of its obligations under this Agreement.

F.2 City agrees to indemnify, defend (with counsel reasonably approved by County), and hold harmless County and its officers, employees, agents, and volunteers from any and all claims, actions or losses, damages, and/or liability resulting from City's negligent acts or omissions which arise from City's performance of its obligations under this Agreement.

F.3 In the event County and/or City is found to be comparatively at fault for any claim, action, loss or damage which results from their respective obligations under the Agreement, County and/or City shall indemnify the other to the extent of its comparative fault.

G. INSURANCE

City and County are authorized self-insured public entities for purposes of Professional Liability, General Liability, Automobile Liability and Workers' Compensation and warrant that through their insurance

policies or respective programs of self-insurance, they have adequate coverage or resources to protect against liabilities arising out of the performance of the terms, conditions or obligations of this Agreement.

H. SIGNATURES

This Agreement may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute one and the same Agreement. The parties shall be entitled to sign and transmit an electronic signature of this Agreement (whether by facsimile, PDF or other email transmission), which signature shall be binding on the party whose name is contained therein. Each party providing an electronic signature agrees to promptly execute and deliver to the other party an original signed Agreement upon request.

I. ENTIRE AGREEMENT

This Agreement, including Attachment I, which is attached hereto and incorporated by reference, represents the final, complete and exclusive agreement between the parties hereto. Any prior agreement, promises, negotiations or representations relating to the subject matter of this Agreement not expressly set forth herein are of no force or effect. This Agreement is executed without reliance upon any promise, warranty or representation by any party or any representative of any party other than those expressly contained herein. Each party has carefully read this Agreement and signs the same of its own free will.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, County and City have each caused this Agreement to be subscribed by its respective duly authorized officers, on its behalf.

SAN BERNARDINO COUNTY

►

Name: _____

Title: Chief Financial Officer

CITY OF RIALTO

By ► _____

(Authorized signature - sign in blue ink)

Name _____

(Print or type name of person signing contract)

Title _____

(Print or Type)

Dated: _____

_____

CITY OF RIALTO

By ► _____

(Authorized signature - sign in blue ink)

Name _____

(Print or type name of person signing contract)

Title _____

(Print or Type)

Dated: _____

COUNTY USE ONLY

Approved as to Legal Form	Reviewed for Contract Compliance	Reviewed/Approved by Department
►	►	►
Charles Phan, Deputy County Counsel		
Date	Date	Date

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 prefe**rence 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*") con**ditions 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.

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[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 Psychia**try'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.