INTERLOCAL AGREEMENT GOVERNING USE OF VOLUSIA COUNTY

REGIONAL OPIOID SETTLEMENT FUNDS

THIS INTERLOCAL AGREEMENT ("Agreement") is made and entered into as of this 26 day of January 2022, by and between Volusia County, a political subdivision of the State of Florida, hereinafter referred to as the "County," and the City of Daytona Beach, the City of Daytona Beach Shores, the City of DeBary, the City of DeLand, the City of Deltona, the City of Edgewater, the City of Holly Hill, the City of Lake Helen, the City of New Smyrna Beach, ~~the City of Oak Hill~~; the City of Orange City; the City of Ormond Beach; ~~the Town of Pierson~~; the Town of Ponce-Inlet; the City of Port Orange; ~~and the City of South Daytona~~; hereinafter referred to as the "Cities."

WHEREAS, a local, state and national crisis arose as a result of the manufacture, distribution and over-prescribing of opioid analgesics ("opioids") and resulted in opioid overdoses and addictions throughout municipalities, counties, states and the nation; and

WHEREAS, Volusia County and the municipalities therein are not immune from this nationwide crisis; an

WHEREAS, in April of 2021, a collaborative working group known as the Volusia County Opioid Task Force, hereinafter "Opioid Task Force", consisting of various knowledgeable staff of the local government entities assembled in response to the alarming increase in opioid related drug misuse and opioid-related deaths within the geographic boundaries of Volusia County; and

WHEREAS, the Opioid Task Force will continue to provide local governments with relevant information on the opioid national crises as well as information and analysis on the

nature, extent, and problems in Volusia County and on opioid-related programs consistent with the State MOU; and

WHEREAS, the crisis has caused and is causing an undue strain on local government finances to implement programing to combat the opioid epidemic, to mitigate the harmful effects of the opioid epidemic in the community, and to increase educational campaigns to counteract misinformation about the addictive nature and harmful effects of opioids; and

WHEREAS, the opioid crisis is as pronounced within Volusia County and within certain municipalities within Volusia County as it was throughout most of the harder hit areas in the state of Florida and in the United States and despite the resources expended on combatting the epidemic, the opioid epidemic continues to impact the local community; and

WHEREAS, as a result of the national opioid crisis, many governmental entities throughout the country filed lawsuits against opioid manufacturers, distributors, and retailers, hereinafter referred to as the "defendants", to hold them accountable for the damage caused by their misfeasance, nonfeasance and malfeasance, as well as to recover monetary damages for past harm and financial compensation for ongoing and future abatement efforts; and

WHEREAS, four governmental entities in Volusia County deemed the opioid crisis significant enough to secure litigation counsel and individually elect to file suit against the defendants to wit: Deltona, Daytona Beach, Ormond Beach, and Daytona Beach Shores, (hereinafter referred to as the "MDL Cities") and the County; and

WHEREAS, the lawsuits filed by the MDL Cities and the County were consolidated with other lawsuits filed by state, tribal and local governmental entities into what is known as

the National Prescription Opiate Litigation in the United States District Court of the Northern District of Ohio, Eastern Division, case number I : 17-MD-2804; and

WHEREAS, as a result of this litigation, multiple defendants have begun to negotiate settlements; and

WHEREAS, the Attorney General for the State of Florida (hereinafter "Attorney General") anticipates that Settlement funds will be distributed to the State of Florida over multiple years as part of a global settlement, and not directly to the MDL Cities and County, despite their position as party plaintiffs; and

WHEREAS, the Attorney General has proposed entering into agreements with local governments within the State of Florida to receive Settlement funds. This agreement (hereinafter referred to as the "State MOU"), as currently drafted, divides settlement funds into three portions designated as City County, Regional and State funds; and

WHEREAS, it is anticipated that the State MOU will set forth the amount and manner of distribution of City/County and Regional Settlement funds within Florida, the requirements to receive and manage Regional funds, and the purposes for which Regional funds may be used. The approved uses in the State MOU for which Regional funds may be used are attached as Exhibit A; and

WHEREAS, the parties recognize that local control over Regional Settlement funds is in the best interest of all persons within the geographic boundaries of Volusia County and ensures that Settlement funds are available and used to address opioid-related impacts within Volusia County and are, therefore, committed to the County qualifying as a "Qualified County" and thereby receiving Regional funds pursuant to the State MOU; and

WHEREAS, Volusia County is currently providing or contracting to provide substance abuse, prevention, recovery, and/or treatment services to the citizens in Volusia County; and

WHEREAS, Volusia County currently has programs and policies for abatement of opioid and other substance abuse, prevention, recovery, or treatment services that may be enhanced or supplemented, including, but not limited to: carrying of Narcan by law enforcement officers, first responders, and corrections officers; pro-active support systems such as educational materials and services to reach at-risk individuals identified through historical opioid events and historical locations of events; as well as intervention for individuals suffering from opioid abuse in the criminal justice system; and

WHEREAS, the State MOU requires that in order for Volusia County to become a Qualified County eligible to receive Regional Funding, there must be an interlocal agreement among Volusia County and Municipalities, as defined in the MOU, with combined population exceeding 50% of the total population of the Municipalities within Volusia County, with the term "Municipalities" being defined for the purpose in this Agreement as those municipalities with a population of 10,000 or more as required by the State MOU; or with population less than 10,000 who were party plaintiffs; population for purposes of the MOU is determined by specific Census data; and

WHEREAS, historically, government-funded programming geared toward abating the opioid crisis has been data driven based upon community impacts without regard to governmental jurisdictional boundaries; and

WHEREAS, this interlocal provides for the appointment to the Opioid Abatement Funding Advisory Board, which shall review and make recommendations on Volusia County's

abatement plan and funding considerations consistent with the abatement plan and State MOU; and

WHEREAS, the parties recognize that it is in the best interest of the County and the Cities to enter into this interlocal agreement to ensure Volusia County is a "Qualified County" to receive Regional Funding pursuant to the State MOU.

NOW, THEREFORE, in consideration of the covenants herein contained, and other good and valuable consideration, the patties agree as follows:

Section 1. DEFINITIONS

A. Unless otherwise defined herein, all defined terms in the State MOU are incorporated herein and shall have the same meanings as in the State MOU.

B. "Volusia County Regional Funding" shall mean the amount of the Regional Funding paid to Volusia County in its role as a Qualified County.

Section 2. CONDITIONS PRECEDENT

This Agreement shall become effective on the Commencement Date set forth in Section 4, so long as the following conditions precedent have been satisfied:

A. Execution of this Agreement by the County and the governing bodies of the municipalities as required by the State MOU to enable Volusia County to become a Qualified County and directly receive Volusia County Regional Funding; and

B. Execution of all documents necessary to effectuate the State MOU in its final form; and

C. Volusia County being determined by the State of Florida to qualify as a "Qualified County" to receive Regional Funding under the State MOU; and

D. Filing of this Agreement with the Clerk of the Circuit Court for Volusia County as required by Florida Statutes, Section 163.01.

Section 3. EXECUTION

This Agreement may be signed in counterparts by the parties hereto.

Section 4. TERM

The term of this Agreement and the obligations hereunder commences upon the satisfaction of all conditions precedent, runs concurrently with the State MOU, and will continue until one (l) year after the expenditure of all Volusia County Regional Funding, unless otherwise terminated in accordance with the provisions of the State MOU. Obligations under this Agreement which by their nature should survive, including, but not limited to any and all obligations relating to record retention, audit, and indemnification will remain in effect after termination or expiration of this Agreement..

Section 5. BOARD

A. Volusia County Regional Funding will be used in accordance with the requirements of the State MOU, and guidelines set forth by a board established by this Interlocal Agreement (hereinafter referred to as the "Opioid Abatement Funding Advisory Board" or "Advisory Board"), which will include utilizing information, data, and projections provided by the Opioid Taskforce.

    i. Opioid Abatement Funding Advisory Board membership shall be comprised of the following members, who should have experience with law enforcement, fire rescue, substance abuse treatment, or other relevant experience, appointed for two-year terms:

1. One member appointed by the City of Daytona Beach;
2. One member appointed by the City of Daytona Beach Shores;
3. One member appointed by the City of DeBary;
4. One member appointed by the City of DeLand;
5. One member appointed by the City of Deltona;
6. One member appointed by the City of Edgewater;
7. One member appointed by the City of Holly Hill;
8. ~~One member appointed by the City of Lake Helen;~~
9. One member appointed by the City of New Smyrna Beach;
10. ~~One member appointed by the City of Oak Hill;~~
11. One member appointed by the City of Orange City;
12. One member appointed by the City of Ormond Beach;
13. ~~One member appointed by the Town of Pierson;~~
14. One member appointed by the Town of Ponce Inlet;
15. One member appointed by the City of Port Orange;
16. ~~One member appointed by the City of South Daytona;~~
17. One member appointed by the Volusia County Council.

B. The Opioid Abatement Funding Advisory Board shall meet regularly and as often as needed to effectuate its responsibilities, but no less than semi-annually and on a schedule which allows the Opioid Task Force to provide the data compiled for and arising out of its semi-annual meeting to the Opioid Abatement Funding Advisory

Board for review and consideration. A majority of the total membership of the Opioid Abatement Funding Advisory Board constitutes a quorum.

C. The Opioid Abatement Funding Advisory Board shall establish bylaws and an annual process which must include the following:

   a. A date certain each year by which the Opioid Abatement Funding Advisory Board must meet and review the data available from previous years, tending to evidence the local status of the opioid epidemic and the effect of abatement programming.

   b. A member of the Advisory Board shall abstain from voting on a proposal for funding a program or service provided by that member's local government.

   c. The Opioid Abatement Funding Advisory Board must review the programs and services of the beneficiaries of Volusia County Regional Funds to determine the outcome of such programs and services in order to hold beneficiaries accountable.

   d. The Opioid Abatement Funding Advisory Board must annually make recommendations on funding, programs, services, and location priorities for the upcoming year(s) ("Opioid Abatement Funding Advisory Board Priority List," "Priority List," or "Abatement Plan"). County Council shall have final approval of the Abatement Plan, or any amendments thereto.

D. The County shall perform competitive solicitations for programming and services based on the Opioid Abatement Funding Advisory Board Priority List in accordance

with the procurement process in Chapter 2 of the Code of Ordinances, County of Volusia.

E. Volusia County Regional Funding may be used to enhance current programs or develop new programs consistent with the State MOU. Regional funding is not intended to supplant current funding sources and general funds, and staff will continue to seek funding for opioid related abatement at the levels opioid abatement programs were funded as of the effective date of this agreement.

F. Final Review recommendations will be approved by the Opioid Abatement Funding Advisory Board, who shall present recommendations to the County Council for approval. The County Council shall approve Opioid Abatement Funding Advisory Board recommendations by a majority vote of the members present unless the County Council rejects such recommendations by a majority vote of the County Council members present. In the event of such rejection, the County Council shall determine and approve by a majority vote of the members present the expenditure of the Regional Funds in accordance with the State MOU.

G. The Opioid Abatement Funding Advisory Board shall recommend and the County Council shall use its best efforts to fund services and programs that are available to all residents of Volusia County and shall strive to allocate funding and services in a manner that equally benefits all residents of Volusia County.

Section 6. ADMINISTRATIVE COSTS

The County is responsible for administering the "Regional Funds" remitted pursuant to the State MOU and, therefore County staff will support the Opioid Abatement Funding

Advisory Board and shall provide all support services including but not limited to legal services, as well as contract management, program monitoring, and reporting required by the State MOU and is entitled to the maximum allowable administrative fee pursuant to the State MOU. The administrative fee will be deducted annually from the amount of available Volusia County Regional Funds, and the remaining Volusia County Regional Funds will be spent as provided in the State MOU and as provided herein.

Section 7. LOCAL GOVERNMENT REPORTING REQUIREMENTS

To the extent that local governmental entity receives Volusia County Regional Funds directly from the County, any local governmental entity so receiving funds must spend such funds for Approved Purposes and must timely satisfy all reporting requirements of the MOU. Failure to comply with this provision may disqualify the local governmental entity from further direct receipt of Volusia County Regional Funds.

Section 8. NON-APPROPRIATION

This Agreement is not a general obligation of the County. It is understood that neither this Agreement nor any representation by any County official, officer or employee creates any obligation to appropriate or make monies available for the purposes of the Agreement beyond the fiscal year in which this Agreement is executed. The obligations of the County as to funding required pursuant to the Agreement are limited to an obligation in any given fiscal year to budget and appropriate from Volusia County Regional Funds annually which are designated for regional use pursuant to the terms of the State MOU. No liability shall be incurred by the County beyond the monies budgeted and available for the purpose of the Agreement. If funds are not received by the County for any or all of this Agreement for a new fiscal period, the

County is not obligated to pay or spend any sums contemplated by this Agreement beyond the portions for which funds were received and appropriated. The County agrees to promptly notify the Cities in writing of any subsequent non-appropriation, and upon such notice, this Agreement will terminate on the last day of the current fiscal year without penalty to the County and all undistributed funds will be spent for programs previously proposed by the Opioid Abatement Funding Advisory Board and adopted by the County Council.

Section 9. INDEMNIFICATION

Each City and the County shall be responsible for their respective employees' acts of negligence when such employees are acting within the scope of their employment and shall only be liable for any damages resulting from said negligence to the extent permitted by Section 768.28, Florida Statues. Nothing herein shall be construed as a waiver of sovereign immunity, or the provisions of F S. § 768.28, by either Party. Nothing herein shall be construed as consent by either Party to be sued by third parties for any matter arising out of this Agreement.

Section 10. SEVERABILITY

If any provision of this Agreement is held invalid, the invalidity shall not affect other provisions of the Agreement which can be given effect without the invalid provision or application, and to this end, the provisions of this Agreement are severable.

Section 11 AMENDMENTS TO AGREEMENT

This Agreement may be amended, in writing, upon the express written approval of the governing bodies of all the parties.

Section 12. FILING OF AGREEMENT

This Agreement shall be filed with the Clerk of the Circuit court as provided in Section

163.01(11), Florida Statutes.

Section 13. GOVERNING LAW

The laws of the State of Florida shall govern this Agreement.

IN WITNESS WHEREOF, the parties to this Agreement have caused their names to be affixed hereto by the proper officers thereof, as of the day and year first above written.

[SIGNATURE PAGES TO FOLLOW]

ATTEST:

COUNTY OF VOLUSIA, a political subdivision of the State of Florida

BY: Barbara Girtman

George Recktenwald
County Manager

Barbara Girtman
County Vice-Chair

DATE: 1/26/22

ATTEST:

CITY OF DAYTONA BEACH, a Florida municipal corporation

Letitia LaMagna

Letitia LaMagna, City Clerk

BY: Derrick Henry

Derrick Henry
Mayor

DATE: 1-21-22

ATTEST:

CITY OF DAYTONA BEACH SHORES, a Florida municipal corporation

BY: Nancy J. Miller

Michael T. Booker, City Manager

Nancy J. Miller, Mayor

DATE: Dec. 14, 2021

ATTEST:

Annette Hatch, CMC, City Clerk

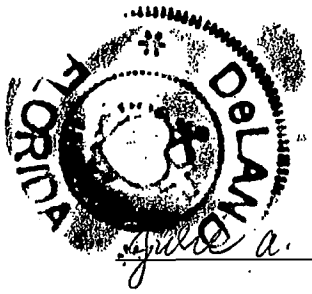
DATE: January 5, 2022

CITY OF DEBARY, a Florida municipal corporation

BY: _____

Karen Chasez
Mayor

ATTEST:



Julie A. Hennessy

CITY OF DELAND, a Florida municipal corporation

BY: Robert F. Apgar

Robert F. Apgar
Mayor

DATE: 1.3.2022

ATTEST:

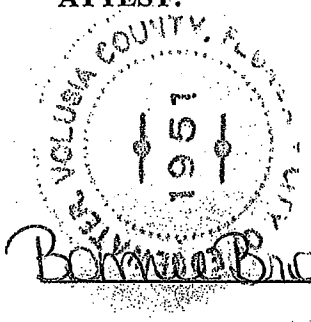
CITY OF DELTONA, a Florida municipal corporation

BY: _____

Heidi K. Herzberg
Mayor

DATE: 1-3-22

ATTEST:



Barbara Brown

DATE: 1/10/2022

CITY OF EDGEWATER, a Florida municipal corporation

BY: _____

Michael Thomas
Mayor

ATTEST:

CITY OF HOLLY HILL, a Florida municipal corporation

BY: _____

Chris Via
Mayor

DATE: 12/16/21

ATTEST:

CITY OF LAKE HELEN, a Florida municipal corporation

BY: _____

Cameron Lane
Mayor

DATE: 1/26/22

ATTEST:

Kelly McQuillen
City Clerk

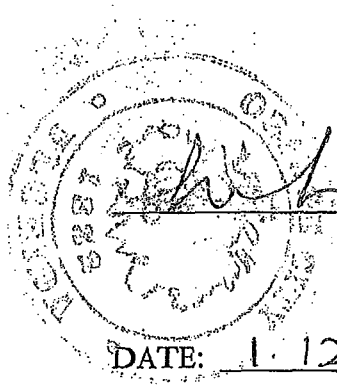
DATE: 1/11/2022

CITY OF NEW SMYRNA BEACH, a Florida municipal corporation

BY: _____

Russ Owen
Mayor

ATTEST:



City Clerk

DATE: 1·12·2022

CITY OF ORANGE CITY, a Florida municipal corporation

BY: _____

Gary Blair
Mayor

ATTEST:

Joyce A. Shanahan
City Manager

DATE: January 18, 2022

CITY OF ORMOND BEACH, a Florida municipal corporation

BY: _____

Bill Partington
Mayor

ATTEST:

TOWN OF PONCE INLET, a Florida municipal corporation

BY: _____

Lois A. Paritsky
Mayor

DATE: 12/17/2021

ATTEST:

CITY OF PORT ORANGE, a Florida municipal corporation

BY: _____

Donald O. Burnette
Mayor

DATE: 1/18/2022

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**")[, such that a minimum of __% of the [aggregate] state-level abatement distributions shall be spent on [one or more of] them annually].[1]

A. Naloxone or other FDA-approved drug to reverse opioid overdoses

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

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

B. Medication-Assisted Treatment ("MAT") Distribution and other opioid-related treatment

1. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals;

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. 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 with other support services.

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 Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

D. Expanding Treatment for Neonatal Abstinence Syndrome

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.

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[1] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

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

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, the following:[2]

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

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any 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. 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.

8. 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. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training,

[2] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. [Intentionally Blank – to be cleaned up later for numbering]

13. 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.

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

15. Development and dissemination of 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 treatment for or 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 following:

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 medication 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. 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 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, the following:

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 Screening, Brief Intervention and Referral to Treatment (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. 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, the following:

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:

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

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

c. "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;

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

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

f. 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 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, the following:

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. Training for obstetricians or other healthcare personnel that 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; 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 Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

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

7. Enhanced family supports 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. 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. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with 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. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

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

a. Increase the number of prescribers using PDMPs;

b. 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

c. 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. Increase electronic prescribing to prevent diversion or forgery.

8. Educate 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. Fund 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. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. Support 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. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund 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 of 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 other 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. Increase 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, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities provide 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. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop 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. Educate 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. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support 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. Provide 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. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Educate 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, facilitation, 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; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related 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, the following:

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.