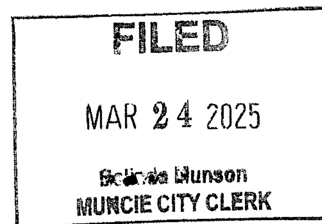


RESOLUTION 11-25

A RESOLUTION OF THE COMMON COUNCIL OF THE CITY OF MUNCIE ESTABLISHING AN OPIOID FUND ADVISORY COMMITTEE

WHEREAS, Indiana has seen more than 2,000 opioid overdose deaths each year since 2020; and

WHEREAS, Delaware County ranks 3rd in total drug overdose fatalities in the state, and 11th in non-fatal overdose emergency room visits; and

WHEREAS, the State of Indiana has received more than $980 million in settlements from cases against opioid manufacturers and distributors; and

WHEREAS, the City of Muncie has received more than $520,000.00 in unrestricted funds and more than $1,130,000.00 in restricted funds; and

WHEREAS, the City of Muncie will continue to receive distributions from the state fund through 2038; and

WHEREAS, the State of Indiana has guidelines for the use of the restricted opioid settlement funds; and

WHEREAS, the Common Council of the City of Muncie recognizes that the opioid epidemic has a compounding ripple effect throughout Muncie affecting public health, economic opportunities, and the quality of life of all Muncie residents; and

WHEREAS, the Common Council of the City of Muncie seeks to fight the epidemic and the negative impacts said epidemic has on our City and its residents by choosing the best use of these once-in-a-lifetime opioid settlement funds; and

WHEREAS, the Common Council of the City of Muncie is committed to ensuring that these restricted funds are used impartially, according to evidence-based practices, and are chosen by experts and professionals who understand best how to make the biggest impact specific to Muncie to ameliorate the effects of the opioid crisis; and

WHEREAS, the State of Indiana's Opioid Settlement & Litigation section recommends creating a committee to oversee these funds, and other cities and counties throughout the State of Indiana have done so; and

WHEREAS, the Common Council of the City of Muncie desires to create an Opioid Fund Advisory Committee that will be responsible for recommending the use of the funds in order to best meet the needs of Muncie's opioid and drug abuse problems; and

NOW, THEREFORE, BE IT RESOLVED BY THE COMMON COUNCIL OF THE CITY OF MUNCIE AS FOLLOWS:

Section 1 – Establishment of Committee: The Common Council of the City of Muncie hereby establishes an Opioid Fund Advisory Committee consisting of seven (7) bipartisan individuals to be appointed by the Mayor of the City of Muncie and the Common Council of the City of Muncie, as well as one ex-officio member without a vote, namely the Mayor, City Controller, or other member of the City's administration with knowledge of the fund and its finances. The Opioid Fund Advisory Committee shall consist of no more than four (4) members from a single political party. Each member of the Opioid Fund Advisory Committee shall satisfy at least one (1) of the following criteria, with no more than two (2) members from any one category:

- Substance use and mental health providers;
- Persons with lived experience from opioid use disorder;
- Public health professionals;
- Medical professionals with experience treating substance use;
- Representatives of Muncie's neighborhoods with the highest number of drug overdoses or usage;
- Persons who have lost family members to drug overdose;
- Employees/volunteers/advocates of community prevention, treatment, recovery, and/or harm reduction organizations/groups;
- First responders;
- Muncie Community Schools family navigators/social workers;
- Social workers who work with people with substance use disorder and/or in recovery;
- Persons working specifically with the unhoused and/or underhoused, or persons working within organizations working specifically with the unhoused and/or underhoused; or
- Delaware County Health Department employees.

All members shall be Muncie residents and/or be employed or volunteer in Muncie in a capacity listed in the above categories.

Section 2 – Appointments of Committee:

A. In addition to the above parameters, the Opioid Fund Advisory Committee appointments shall be as follows:
    a. Three (3) members appointed by the Mayor of the City of Muncie;
    b. Three (3) members appointed by the Common Council of the City of Muncie;
    c. One (1) member chosen by the other six members.
    d. One (1) ex-officio chosen by the Mayor who has knowledge of the opioid funds and the finances of the City.

B. Members shall serve terms of two (2) years in duration, which the option of reappointment. To create staggered appointments, the terms of one (1) appointment by the Mayor, one (1) appointment by the City Council, and the member chosen by the six (6) appointed members will expire on May 31, 2026. The initial terms of the remaining four (4) members will expire on May 31, 2027.

Section 3 – Duration of Committee: The Opioid Fund Advisory Committee shall remain in existence until such time that all funds distributed to the City of Muncie by the State of Indiana have been allocated and/or until termination by resolution of the Common Council of the City of Muncie.

Section 4 – Duties of the Opioid Fund Advisory Committee: The purpose of the Opioid Fund Advisory Committee will be to research and recommend projects or initiatives that should be funded with the settlement funds. The Opioid Fund Advisory Committee shall focus on understanding the issue, identifying the specific needs of Muncie, exploring evidence-informed initiatives, and gathering local input regarding the best use of the settlement funds. The Committee shall use the attached "State of Indiana Recommendations for Spending National Opioid Settlement Funds" and its Exhibit E which lists approved uses of the funds as guidelines.

The Opioid Fund Advisory Committee should also seek to partner with the Addictions Coalition of Delaware County, Meridian Health Services, IU Health, Open Door Health Services, Delaware County Drug Prevention Council, and other organizations committed to addressing substance addiction.

Section 5 – Findings and Recommendations to Common Council: At the first City Council meeting following each meeting of the Opioid Fund Advisory Committee, a member of the Committee shall provide a report to the Mayor of the City of Muncie and to the Common Council of the City of Muncie.

Section 6 – Meeting Format: The Opioid Fund Advisory Committee will be responsible for conducting meetings in compliance with the Indiana Open Door Law. Meetings shall be conducted in a manner to encourage transparency.

Section 7 - This Resolution shall be in full force and effect from after its passage by the Common Council and its approval by the Mayor of the City of Muncie, Indiana.

Passed by the Common Council of the City of Muncie, Indiana, this ____ day of ___________, 2025.

	Yeas	Nays	Abstained	Absent
Jeff Green	_____	_____	_____	_____
Nora Powell	_____	_____	_____	_____
Brandon Garrett	_____	_____	_____	_____
Sara Gullion	_____	_____	_____	_____

Jerry D. Dishman	____	____	____	____
Harold Mason	____	____	____	____
Dale Basham	____	____	____	____
William McIntosh	____	____	____	____
Ro Selvey	____	____	____	____

____
President, Common Council

ATTEST:

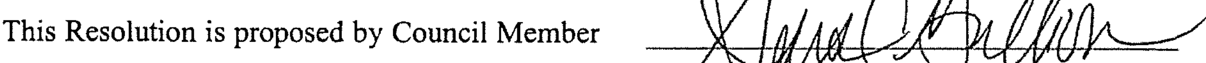
____
Belinda Munson, City Clerk

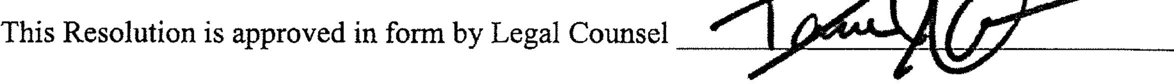
Presented by me to the Mayor for his approval this ___ day of __________________, 2025.

____
Belinda Munson, City Clerk

The above Resolution is approved/vetoed by me this ___ day of __________________, 2025.

____
Dan Ridenour, Mayor


This Resolution is proposed by Council Member ______________________________


This Resolution is approved in form by Legal Counsel ______________________________

State of Indiana Recommendations for Spending National Opioid Settlement Funds
Adopted by the Indiana Commission to Combat Substance Use Disorder on 11/14/2024

Guidance For Fund #2257 Opioid Settlement Restricted ONLY

The State of Indiana has reached multiple settlements with major pharmaceutical companies, distributors, and related firms as part of the State's ongoing commitment to accountability in addressing substance use. The settlements will provide Indiana with more than $980 million over an 18-year period.

The settlements are governed by Ind. Code §4-6-15, which defines the following distribution structure (unless a settlement specifically prohibits or limits unrestricted use):

- **Fifteen percent (15%)** for unrestricted use for the benefit of the state.
- **Thirty-five percent (35%)** restricted for statewide treatment, education, and prevention programs for opioid use disorder and any co-occurring substance use disorder or mental health issues, as defined or required by the settlement documents or court order.
- **Fifteen percent (15%)** for unrestricted use, distributed to cities, counties, and towns based on a weighted distribution formula reflecting opioid impacts in communities.
- **Thirty-five percent (35%)** distributed to cities, counties, and towns based on a weighted distribution formula reflecting opioid impacts in communities, restricted for programs of treatment, prevention, and care that are best practices as designed or required by the settlement documents or court order (*restricted/abatement*)
  - If a city or town's annual distribution is less than $5,000, their annual distribution must instead be distributed to the county in which the city or town is located.

This resource aims to assist Indiana subdivisions in strategically allocating their **35% restricted distribution** of opioid settlement funds received under Ind. Code §4-6-15. By utilizing this resource, communities can develop targeted plans of action to effectively address substance use disorder.

Development of this resource comes in response to questions from local units of government about allowable uses and following the 2024 report on spending of opioid settlement funds by local units of government. This resource is to be used in conjunction with Exhibit E of the National Opioid Settlement agreement, which outlines the allowable uses for abatement. It is our intention to develop a more detailed resource to guide spending, especially for communities that may not be receiving a significant amount of funds.

While this resource addresses restricted funds, many communities around the state have decided to use 100% of their settlement funds both restricted and unrestricted for abatement purposes.

Disclaimer: Information in this document is not intended to take the place of state statute, regulations, or settlement documents. The information in this document is subject to change and is not legal advice, therefore, please consult with your own legal counsel for assistance with your legal matters.

Getting Started

1. **Create a Local Advisory Committee:** Forming a committee of internal and external stakeholders to assess community data and existing infrastructure, guide discussions around the use of funds, and propose potential solutions or strategies for investment is critical to creating a fair distribution process. It is important to ensure this group understands the allowable uses of abatement funds, outlined in Exhibit E, and includes partners from various sectors, including but not limited to:
   - Persons with lived experience
   - Community Mental Health Centers
   - Schools
   - Substance use and mental health treatment providers
   - Prevention providers
   - Recovery Community Organizations
   - Local Coordinating Council
   - Local Health Department
   - Sheriff's Department
   - Local Justice Reinvestment Advisory Council
   - Community-based organizations
   - Faith-based organizations
   - Social service organizations
   - Community foundation or other health foundations
   - First responders

   The committee's focus should include understanding the problem, identifying the needs of the community, exploring activities and evidence-informed initiatives that like-communities have implemented, and gathering local input. The committee should consider capping administrative and indirect costs, including but not limited to consulting, grant writing, compliance, staff salary and benefits, and office equipment, positions that are able to bill directly to insurance or Medicaid for services, and how to utilize unrestricted funds to supplement abatement funds.

2. **Conduct a Local Needs Assessment:** To start, it is crucial to understand the approved uses for settlement funds, found in Exhibit E of the National Opioid Settlement. However, it is recommended to prioritize local needs assessments to begin. By utilizing publicly accessible data such as data on overdose deaths and emergency department visits and understanding the resources currently available in a community, communities can identify areas of greatest need and use this data to pinpoint specific strategies to consider.

   Where to locate data:
   - Next Level Recovery Data Dashboard
   - Indiana Department of Health Drug Overdose Dashboard
   - Indiana Mental Health-Related Events Dashboard
   - Indiana Fatal Drug Overdose Touchpoints Dashboard

3. **Consider adopting the following principles** to guide local spending of the national settlements:
    - Spend the money to save lives.
    - Use evidence to guide spending.
    - Invest in youth prevention.
    - Develop a fair and transparent process for deciding where to spend the funding.

4. **Commit to Transparency:** Transparency in the distribution and management of funds is crucial for building trust with stakeholders and ensuring accountability. To ensure transparency, local units of government are encouraged to:
    - Create a webpage and share relevant information and updates, including but not limited to identification of committee members and points of contact, publication of proposed plans, etc.
    - Host town halls or listening sessions to solicit public input
    - Accept written feedback on the developed plan, giving those with particular insights—such as families and other members of the recovery community—an opportunity to weigh in.

5. **Consider Existing Infrastructure:** As part of this process, it is important to understand the infrastructure that currently exists in the community and the surrounding region and how your community can better integrate and connect services with another.
    - DMHA-certified treatment providers
    - Regional recovery hubs
    - Certified Recovery Community Organizations (RCOs)
    - Recovery Works
    - Prevention of Substance Misuse and Mental Health Promotion
    - Naloxone
    - Local Health Departments
    - Local Coordinating Council

6. **Spend Dollars in Accordance with:**
    - **Exhibit E:** As part of the settlement agreement, Exhibit E was developed to govern spending of funds restricted for abatement use only.
        - Abatement funds may not be used to supplant existing state or local government funding.
    - **Department of Local Government Finance regulations**
    - **Established procurement procedures and purchasing guidelines of the local unit of government spending funds and the uniform standards published by the State Board of Accounts.**

Items Not Included in Allowable Expenses Under Exhibit E:

This list was developed in consultation with other states and settlement negotiators in alignment with Exhibit E.

- Activities that are not evidence-based or promising practices for opioid abatement
- Activities that are funded through other program grants or activities
- Law enforcement activities related to interdiction or criminal processing
- Law Enforcement equipment (e.g. vests, guns, body cameras, radios, radio batteries, batons, rifle suppressors, uniforms, K-9, tasers, vehicles, parking ticket books and tow away signage, fuel for drug incinerators, cell phone extraction software and equipment, fingerprint scanners, pill counters)
- Mass spectrometers of any kind, are not allowable for interdiction purposes
- Non-FDA-approved medications related to the treatment of substance use disorders
- Medications, medical services or equipment not related to the treatment of SUD or mental health conditions (e.g., automated external defibrillators [AEDs], first aid kits, gloves, electrodes etc.)
- Drug testing
- Vape Sensors
- Developing infrastructure or investing in equipment or capital projects not directly related to prevention, treatment, harm reduction, or recovery services (e.g. sheds, garage doors, etc.)
- Automated External Defibrillators AEDs
- Promotional materials, including items with logo embroidery or screen printing.
- Capital expenses unrelated to SUD treatment

Strategy Considerations for Subdivisions Receiving Lower Payment Amounts

While your local subdivision may not be receiving a large amount of funding year to year, there are still approaches you may take to make upstream changes to combat substance use. One solution to consider is partnering with neighboring counties, municipalities, and towns to help support local efforts. Collaboration creates an opportunity for a pooling of resources that can lead to a wider range of community benefit.

Subdivisions receiving lower amounts of funding may also consider focusing on one priority area at a time rather than attempting to address all priority areas and spreading funds too thin. For example, this may look like addressing the need to bring a Medication for Opioid Use Disorder (MOUD) provider into your community if that is identified as a gap in the community. Another example may be to work with a local community-based organization to implement education via school-based or after school programming. The subdivision may also consider letting the funding build up over time to invest in larger strategic approaches once funding has accumulated. Subdivisions may also consider applying for grant opportunities through the

Indiana Family and Social Services Administration (FSSA) - Division of Mental Health and Addiction (DMHA) as available. Information can be found here.

If you are interested in pooling your funds or combining efforts with other subdivisions in your community, below are resources to assist in this effort:

- National Association of Counties and National League of Cities: Building on a strong history of collaboration, including the National City-County Task Force on Opioids, NACo and the National League of Cities examined preliminary data on the distribution of opioid settlement funds across cities, counties, and states. This brief highlights how cities and counties are working together to address the drug epidemic, including pooling opioid settlement funds to create a more comprehensive system of care for people with substance use disorder.
    - Download the brief to learn about the allocation of opioid settlement funds between cities, counties, and states, and how cities and counties are coordinating to maximize the impact of these funds.
- Accelerate Indiana Municipalities (AIM): AIM serves as the official voice of municipal government in Indiana, with more than 460 cities and towns as members. In addition to its annual conference, the association hosts regular training sessions and workshops throughout the year, including educational opportunities related to the National Opioid Settlement.
- Counties in Action provides examples of what counties are doing across the nation to assist with your initial brainstorming of strategy allocations.

Questions may be directed to inopioidsettlement.us@egis-group.com.

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[1]

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

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

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

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

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

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

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

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

[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.

C. PREGNANT & POSTPARTUM WOMEN

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

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

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

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

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

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

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

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

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

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

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

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

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

F. TREATMENT FOR INCARCERATED POPULATION

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

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

G. PREVENTION PROGRAMS

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

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

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

4. Funding for community drug disposal programs; and

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

H. EXPANDING SYRINGE SERVICE PROGRAMS

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

[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.

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

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

B. <u>SUPPORT PEOPLE IN TREATMENT AND RECOVERY</u>

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. <u>PREVENT MISUSE OF OPIOIDS</u>

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.