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TERESA K. PETRO
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RECORDED AS PRESENTED

INTERLOCAL AGREEMENT ESTABLISHING THE JOHNSON COUNTY, INDIANA OPIOID REMEDIATION GRANT PROGRAM ADVISORY BOARD

WHEREAS, Johnson County, Indiana, by and through its Board of Commissioners ("County") is a government organization providing services to the citizens of Johnson County, Indiana;

WHEREAS, the state of Indiana is set to receive approximately $925 million dollars over eighteen (18) years as part of several opioid litigation settlements. The settlement funds are governed by Ind. Code § 4-6-15 *et. seq*. whereby funds in both the Local Unrestricted Opioid Settlement Account and Local Abatement Opioid Settlement Account are continuously distributed to participating cities, counties, and towns by formula whereby those cities and towns receiving less than $5,000 annually in abatement funding will have their distribution sent to the county directly; and

WHEREAS, the County, is making available funding opportunities across Johnson County through a grant program, specifically the Johnson County Opioid Remediation Grant Program, to support evidence-based prevention, treatment, recovery, harm reduction, behavioral health workforce, enforcement, jail treatment, recovery residences, and other services and initiatives as allowed under **Exhibit E** of the National Opioid Settlement document; and

WHEREAS, the County as the executive body under Ind. Code § 36-2-2-2, desires to establish an advisory board under Ind. Code § 36-2-3.5-4, made up from members of local government entities, to review the Johnson County Opioid Remediation Grant Program applications and make recommendations to the County for expenditure recommendations and approvals of the opioid settlement funds; and

WHEREAS, Ind. Code § 36-1-7 *et. seq*. provides that governmental entities may enter into inter-local agreements to exercise authorized powers; and

WHEREAS, in accordance with Ind. Code § 36-1-2-5, the Mayor of Franklin, Indiana ("Franklin") serves as the executive body for Franklin, Indiana, and the President of each Town Council serves as the executive for the Towns of Bargersville ("Bargersville"), Edinburgh ("Edinburgh"), New Whiteland ("New Whiteland"), Prince's Lakes ("Prince's Lakes"), Trafalgar ("Trafalgar"), and Whiteland, Indiana ("Whiteland") (collectively as "Parties") and,

WHEREAS, in accordance with Ind. Code § 36-1-2-6, the Johnson County Council serves as the fiscal body for Johnson County, Indiana, the Common Council serves as the fiscal body for Franklin, Indiana, and each respective Town Council serves as the fiscal body for Bargersville, Edinburgh, New Whiteland, Prince's Lakes, Trafalgar, and Whiteland in accordance with that same authority; and,

WHEREAS, the Parties are all located within Johnson County and have each executed Resolutions allowing their restricted opioid funds to remain with the County for appropriation through the Johnson County Opioid Remediation Grant Program; and,

WHEREAS, the Parties have enjoyed a positive working relationship with one another and share the common goal of promoting innovative, collaborative, community-driven, cross-sector responses to substance opioid use disorder issues as allowed under **Exhibit E** of the National Opioid Settlement document outlining the approved abatement uses to the citizens of Johnson County; and

WHEREAS, for these reasons and in furtherance of these common goals, the Parties and Johnson County now desire to enter into this Interlocal Agreement (hereinafter "Agreement") establishing The Johnson County, Indiana Opioid Remediation Grant Program Advisory Board, in accordance with Ind. Code § 36-1-7 *et. seq.*

NOW, THEREFORE, the Parties and the County agree as follows:

1. **Purpose.** The purpose of this Agreement is to establish the Johnson County, Indiana Opioid Remediation Grant Program Advisory Board for the administration of the Johnson County Opioid Remediation Grant Program throughout Johnson County, Indiana.

2. **Joint Board**. This Agreement shall be administered through the Johnson County, Indiana Opioid Remediation Grant Program Advisory Board ("Board") consisting of representatives as specified under Section 4 of this Agreement, pursuant to Ind. Code § 36-1-7-3(a)(5)(B), or their designee. The Board shall have the authority to review and manage the administration of this Agreement and report each Party as specified in Section 6 of this Agreement. The Board shall not have the authority to acquire, hold or dispose of any personal or real property.

3. **Duration**. This Agreement shall be effective upon it being recorded in the Office of the Johnson County Recorder, after having been adopted and executed by the Parties herein; and shall continue thereafter until terminated by a majority of the parties, or upon the completion of the Indiana Opioid Litigation and Settlement dispersion under Indiana Code §§ 4-6-15. This Agreement shall also be filed with the State Board of Accounts pursuant to Ind. Code § 36-1-7-6, within sixty (60) days after recording.

4. **Board Composition**. The Johnson County Opioid Remediation Grant Program Advisory Board ("Board") shall be composed of:
    a. One (1) member of the County Executive, appointed by the County Executive, shall serve a term of two years.
    b. One (1) member of the County Fiscal body, appointed by the County Executive, shall serve a term of two years.
    c. Two (2) members of the city of Franklin, Indiana's City Council, appointed by the City Council, who shall serve a term of two years.
    d. One (1) member of the Bargersville Town Council, or their designee, appointed by the Town Council, who shall serve a term of two years.

e. One (1) member of the Whiteland Town Council, or their designee, appointed by the Town Council, who shall serve a term of two years.
f. One (1) member of the New Whiteland Town Council, or their designee, appointed by the Town Council, who shall serve a term of two years.
g. One (1) member of the Edinburgh Town Council, or their designee, appointed by the Town Council, who shall serve a term of two years.
h. One (1) member of the Trafalgar Town Council, or their designee, appointed by the Town Council, who shall serve a term of two years.
i. One (1) member of the Prince's Lakes Town Council, or their designee, appointed by the Town Council, who shall serve a term of two years.

5. **Resignation**. If a member is no longer serving in their elected position, resigns from their elected position, or is otherwise removed from the Board prior to the expiration of any two-year term, a replacement member shall be appointed in the same manner as the selection and appointment of the initial member.

6. **Board Duties**. The Board shall screen all grant applications for eligibility, evaluate and score all grant applications, and make recommendations to the County for awarding Opioid Remediation funding in accordance with the Johnson County Opioid Remediation Grant Program and Indiana Code §§ 4-6-15.
    a. The Board shall develop a process for making recommendations and forwarding all relevant information to the County for grant recipients and awarding funds bi-annually or however deemed by the County.

7. **Board Positions**. Officers of the Board shall be a chairperson, a vice-chairperson, and a secretary, with a two (2) year term to be elected by a majority of the Board. The chairperson shall preside over all meetings and perform any other duties as designated by the Board. The vice-chairperson shall act for the chairperson in their absence.

8. **Meetings**. The Board shall conduct their meetings as frequently as deemed necessary by the Chair and in accordance with the applicable Indiana Open Door Laws under Ind. Code § 5-14 *et. seq*.

9. **Quorum**. A majority of voting members of the Board present at any meeting shall constitute a quorum. The continued presence of a quorum is required before any formal action is commenced. All Board business shall be transacted by an affirmative vote of a majority of members present at a meeting in which a quorum is established.

10. **Financing, Staffing, and Supplying**. This Agreement does not implicate the staffing of additional City, Town, or County personnel or the acquisition, holding, or disposal of personal property.

11. **No Joint Undertaking**. The Parties acknowledge and agree that the purpose and intent

of this Agreement is not to undertake the joint exercise of power within the meaning of Ind. Code § 36-1-7-2(a); therefore, this Agreement need not address other matters related to the financing, staffing, budget, administration through a joint board or separate legal entity, or the manner of acquiring, holding and disposing of real and personal property of a joint undertaking. There will be no jointly held property under this Agreement.

12. **Termination.** Any Party may terminate themselves as a party to this Agreement at any time, upon notice to the other parties at its customary address, and without the necessity of cause. The terminating party shall provide Notice of no less than sixty (60) days of its intent to terminate to all other Parties to this Agreement.

13. **Accounting**. To the extent any accounting is required by this Agreement, now or at some future time, the Johnson County Auditor and Treasurer shall have the duty of receiving, disbursing, and accounting for all monies obtained pursuant to this Agreement, all of which is pursuant to Ind. Code § 36-1-7-4, so that approval of the Attorney General for this Agreement is not required.

14. **Governing Law.** This Agreement is entered into in accordance with Ind. Code § 36-1-7 *et. seq*. and Ind. Code § 36-1-7-3. This Agreement shall be governed, construed, and enforced in accordance with the laws of the State of Indiana.

15. **Indemnification.** Johnson County shall completely indemnify, protect and hold harmless the Parties against any and all costs, expenses, liability, losses, claims, suits, and proceedings of any nature whatsoever brought against the Parties arising out of or relating to the terms of this Agreement, unless such costs, expenses, liability, losses, claims, suits, or proceedings arise solely out of the Party's negligence or other breach of duty by any Party.

    Each Party shall completely indemnify, protect and hold harmless Johnson County against any and all costs, expenses, liability, losses, claims, suits, and proceedings of any nature whatsoever brought against Johnson County arising out of or relating to the terms of this Agreement or the Software, unless such costs, expenses, liability, losses, claims, suits, or proceedings arise solely out of Johnson County's negligence or other breach of duty by Johnson County.

16. **Counterparts.** This Agreement may be executed in counterparts, each of which when so executed shall be deemed to be an original, and such counterparts together shall constitute but one and the same instrument, which shall be sufficiently evidenced by any such original counterpart.

17. **Modification**. This Agreement shall not be modified except by a written instrument executed by each Party and in accordance with Indiana law.

18. **Severability**. The invalidity of any section, subsection, clause, or provision of this Agreement shall not affect the validity of the remaining sections, subsections, clauses or provisions of this Agreement.

19. **Entire Agreement**. This Agreement contains the complete and entire agreement between the Parties and the County concerning the subject matter hereof. There are no oral promises, conditions, representations, understandings, interpretations or terms of any kind as conditions or inducements to the execution hereof or in effect between the Parties and Johnson County.

[Signatures to follow]

IN WITNESS WHEREOF, ALL OF WHICH IS AGREED, ADOPTED, and SO APPROVED this 8th day of July, 2024.

JOHNSON COUNTY, INDIANA
BOARD OF COMMISSIONERS

Brian Baird, Chair

Kevin Walls

Ron West

ATTEST:

Elizabeth Alvey, Johnson County Auditor

IN WITNESS WHEREOF, ALL OF WHICH IS AGREED, ADOPTED, and SO APPROVED this 8th day of July, 2024.

JOHNSON COUNTY, INDIANA
COUNTY COUNCIL

Pam Burton, President

John Mallers, Vice-President

Ron Deer

John Dumars

Melinda Griesemer

John Myers

Jonathan T. Myers

ATTEST:

Elizabeth Alvey,
Johnson County Auditor

City of Franklin, Indiana by its Common Council:

Voting Affirmative:

Kenneth Austin, President

Shawn Taylor, Vice President

Jennifer Price

Irene Nalley

Todd A. Shuck

Anne McGuinness

Josh Prine

Voting Opposed:

Kenneth Austin, President

Shawn Taylor, Vice President

Jennifer Price

Irene Nalley

Todd A. Shuck

Anne McGuinness

Josh Prine

Presented by me to the Mayor of the City of Franklin for his approval or veto pursuant to Indiana Code §36-4-6-15 and 16, this 3 day of June 2024 at 6:05 o'clock a.m. (p.m.)

Jan Jones, City Clerk-Treasurer

This Ordinance having been passed by the legislative body and presented to me was _____ by me and duly adopted, pursuant to Indiana Code §36-4-6-16(a)(1) this 3 day of June, 2024 at 6:05 o'clock a.m. (p.m.)

Steve Barnett, Mayor

Attest:

Jan Jones, City Clerk-Treasurer

PASSED AND ADOPTED BY THE TOWN COUNCIL OF BARGERSVILLE, JOHNSON COUNTY, INDIANA THIS 9 DAY OF July 2024.

AYES	NAYS
James Rumell II, President	James Rumell II, President
James Pheifer, Vice President	James Pheifer, Vice President
Susie Qualls	Susie Qualls
Andrew Greenwood	Andrew Greenwood
Ruth Ann Moore	Ruth Ann Moore

Attest:

Sandra Jensen

~~R. Dustin Doyle, Clerk-Treasurer~~

1st Deputy Clerk treasurer

PASSED AND ADOPTED BY THE TOWN COUNCIL OF EDINBURGH, JOHNSON COUNTY, INDIANA THIS 14 DAY OF October 2024.

AYES

Ryan Piercefield, President

Miriam Rooks, Vice President

Debbie Buck, Member

Sherri Sweet, Member

Absent
Michael Bryant, Member

NAYS

Ryan Piercefield, President

Miriam Rooks, Vice President

Debbie Buck, Member

Sherri Sweet, Member

Michael Bryant, Member

Attest:

Rhonda Barrett, Clerk-Treasurer

PASSED AND ADOPTED BY THE TOWN COUNCIL OF NEW WHITELAND, JOHNSON COUNTY, INDIANA THIS 7TH DAY OF AUGUST, 2024.

John Perrin, President

Attest:

Angela DeVoss, Clerk-Treasurer

PASSED AND ADOPTED BY THE TOWN COUNCIL OF PRINCE'S LAKES, JOHNSON COUNTY, INDIANA THIS 15 DAY OF July 2024.

AYES

Greg Nelson, President

Bryan Tearman, Vice President

Charlie Bourne

Kevin Harrison

Lindsey Henson

NAYS

Greg Nelson, President

Bryan Tearman, Vice President

Charlie Bourne

Kevin Harrison

Lindsey Henson

Attest:

Erica Lyden-Giger, Clerk-Treasurer

PASSED AND ADOPTED BY THE TOWN COUNCIL OF TRAFALGAR, JOHNSON COUNTY, INDIANA THIS 21 DAY OF August 2024.

AYES

Jason Ramey, President

Absent
Jessica Jones, Vice President

Jackie Bryant, Member

Ashley Chaney, Member

Mike Peters, Member

NAYS

Jason Ramey, President

Jessica Jones, Vice President

Jackie Bryant, Member

Ashley Chaney, Member

Mike Peters, Member

Attest:

Donna Moore, Clerk-Treasurer

PASSED AND ADOPTED BY THE TOWN COUNCIL OF WHITELAND, JOHNSON COUNTY, INDIANA THIS 10th DAY OF September 2024.

AYES

Richard Hill, President

Tim Brown, Vice President

Brad Goedeker

Debra Hendrickson

Joseph Sayler

NAYS

Richard Hill, President

Tim Brown, Vice President

Brad Goedeker

Debra Hendrickson

Joseph Sayler

Attest:

Melissa Fraser, Clerk-Treasurer

This Instrument Prepared By:

Adam P. Gadberry, Attorney No. 31975-29
Johnson County Attorney
86 W. Court St.
Franklin, IN 46131
(317) 346-4392
agadberry@co.johnson.in.us

Redaction Statement

I affirm, under penalties for perjury, that I have taken reasonable care to redact have social security number in this document, unless required by law.

Adam P. Gadberry, Attorney No. 31975-29

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. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

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

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

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

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

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

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

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

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

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

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

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

    1. Increase the number of prescribers using PDMPs;

    2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing

overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.