Remote HHS and Public Safety Committee Agenda
April 23, 2024 at 5:30 PM
Remote Via Zoom

MEMBERS
Councilor April Fournier, At-Large, Chair
Councilor Roberto Rodriguez, At-Large
Councilor Anna Trevorrow, District 1
Councilor Victoria Pelletier, District 2

To submit written public comment on an agenda item, email HHSPS@portlandmaine.gov. Submissions must be received by 12:00 pm the day before the Health & Human Services and Public Safety meeting to guarantee their inclusion in the agenda packet. All submissions must include the commenter's name and legal address. To help ensure your comment is submitted for the correct item, please include the name of the agenda item (see below).

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1. Announcements

2. Approval of Minutes from March 26th

   a. Minutes from March 26th Meeting

3. Discussion of Community Partners' Recommendation: Permanent Increase to HSC Capacity (Councilor Fournier, Chair)
   The Committee will discuss recommendations, received by community partners at its meeting on March 26, 2024, to permanently increase the capacity of the Homeless Service Center.

4. For Consideration: Proposal to Repeal Section 17-5 of City Code (Councilor Fournier, Chair)
   The Committee will consider a proposal to repeal Sec. 17-5 of the City Code.

5. Finalize 2024 Workplan
   The Committee will vote to finalize its 2024 work plan.

   a. Draft 2024 Work Plan

6. Reminder : City Ordinances Effectively Prohibit Camping on Public Property (Councilor Fournier, Chair)

7. Opioid Settlement Funds Update (Staff)

   a. Opioid Settlement Funds Update Memo

8. Next Meeting: May 14, 2024

Health & Human Services and Public Safety Committee Minutes

Tuesday, March 24, 2024, 5:30pm, Remote Meeting

Committee Attendance: April Fournier, Chair (At-large), Victoria Pelletier (District 2)

Roberto Rodriguez (At Large), Anna Trevorrow (District 1), Regina Phillips.

City Staff: Counsel; Keith Gautreau, Fire Chief; Mark Dubois, Police Chief; Shaza Stephenson, Deputy/Interim Director of HHS; Dena Libner, Assistant City Manager; Greg Jordan, Assistant City Manager, Adam Harr, Executive Assistant for Social Services; Jessie Lemieux, Executive Assistant for Fire.

Outside Panelists: Mary Davis, Housing and Community Development Division Director; Lauren Bowen, Housing Program Coordinator; Cullen Ryan, Executive Director for Community Housing of Maine; Andrew Bove, Vice President of Social Work for Preble Street; Tom Doherty, Executive Director at Milestone.

1. Announcements

2. Review and Approval of Minutes from January 9 and February 13 2024

Minutes were approved

a. Draft Minutes

3. Staff Updates

a. Home Investment Partnership Program (HOME) American Rescue Plan (ARP) Funds

Mary Davis to present HUD

The Cumberland County Home Consortium received approximately 3.6 million in home ARP funding. The city is the lead entity in the home consortium and assumes all of the required administrative tasks for the consortium.

This grant is funded through the American Rescue Plan, but it was allocated through the US Department of Housing and Urban Development (HUD), home program. The allocation plan was approved by the Portland City Council Commissioners in March of 2023, and approved by HUD in May 2023. In that plan we adopted several eligible

funding categories which include supportive services, acquisition and development of non-congregate shelter and the development of affordable rental housing.
4 Qualifying Populations for the funding:

1. Homeless
2. At risk of homelessness
3. Fleeing or attempting to flee domestic violence
4. General other population

Will be submitting the substantial amendment to HUD (one approved at city and county level) with the following proposals:

1.) Identifying a preference for the category of development of affordable rental housing
2.) Changing acquisition of funding to supportive services category
3.) Identifying how individuals would occupy the units that are created under program - using statewide coordinated entry referral method

b. HHS/PD/FD on response to an increase in needles and tenting around warming center

Chief Gautreau - Significant drop in activity, including trash and needles due to warming shelter closing

Shaza - Harm Reduction Team installed 2 large sharps containers inside Freshman Alley. Team collects items regularly.

Chief Dubois - Daily activities consist of removing people from obstructing sidewalks, but are working with other agencies to keep targeted locations clear. Tent removals are successful. Discovered pallets set up on Portland St, to be addressed. Currently 7 male beds at HSC, and more female beds for today's numbers.

4. Panel Discussion - Where have we been, what have we experienced, and where are we going moving forward. HSC opened one year ago.
Connective Tissue - everyone has different needs / be considering of them

a. Homelessness and Housing Provider Panel

Address encampments - homelessness and at risk community members complications in 2023 and solutions going into 2024:

Cullen Ryan - Role has been similar to mission, housing and advocacy. Pulling people together based on needs. Believe we can end homelessness. People need permanent support of housing. 20 organizations work together and know the population by name with a 90% success rate. City of Portland has 3000 people/ year of homelessness. During the pandemic more people were "stuck" . The goal then and now is to work towards addressing the backlog and to house them.

Resources from state to assist -

Housing First - Providing people a place to go
Housing Navigators - Group to assist with securing housing options

Portland's unhoused numbers went up because the demand increased with the new asylum seekers on top of the already high homeless numbers.
282 tents outside

City did 3 important things during this crisis

1. November 30 created space for asylum seekers
2. Adding 50 beds and making more space at the HSC
3. Focused on lowering barriers (like reducing criminal trespassing from supporting shelters) and targeted the population with highest need. By Jan/Feb 90% reduction since October.

Moving forwards the city needs to continue outreach, and really coordinate with other shelters to get people inside. City needs to stay the course.

Andrew Bove- Serving outreach to permanent support of housing provides 3 emergency shelters, 2 for adults.

Outreach is 7 days/all weather/connecting resources to people

Elenas way - Shelter to target folks who are resistant to traditional shelter programs (specialized shelter, 40 people, men and women, chronically homeless)

Promote atomy and choice
Offer beds and hot meals 24 hours a day
No curfew
Overflow storage
Welcome couples - ability to sleep adjacent to each other

Rapid Rehousing Team - Service used here with staff
Free housing first - site based staff supported housing
Preble St will be a HOPE housing location
4th location proposed for a 30 unit space for supported housing
Homelessness is a solvable problem

Tom Doherty - Focus on the power of the relationships as it builds force
Preble St/Home Team Provides:

Ability for outreach teams to create relationships (Home Team 6 days/week)
Engaged Dr Anne Revere - Medical Director
Adding another volunteer Dr to go out into the encampments
(Wound care, myocarditis, provide meaningful on site healthcare)
70% of staff has personal experience with substance abuse (relatability)
Ashleas Place - supporting people with ability to build up rental history
Milestone has beginning stages of recovery (16 beds) for largest in state
Hoping for May 1 to have larger space to provide a larger option with
a dedicated psychiatrist.
People operate at primitive level, food, water, shelter (get them inside)

b. Committee Questions and Discussion

Councilor Fourner - MMO and Behavioral Health Unit are designed to support, from a Council perspective (legislative arm), how can we be more helpful ?

Councilor Rodriguez - Will capacity levels increase long term. Would/should it be full term?
Cullen - We will continue to increase. 208 is our magic number. If not flexible with capacity, we will go back in effectiveness.
Bove- If we want people to stay inside, we have to ensure the space for all seasons.
Doherty - Ensure more capacity than actual need.

Councilor Trevorrow - Do you foresee the numbers leveling out? What are current pressures?
Cullen - We have a "stuck homeless system". Occurred by putting people in hotels. We lost "homeless navigation". We need increased housing navigation - work with landlords (incentivize them). Same numbers in 2024 as in 2019- we are good with the steady pace, but cannot deal with high demand successfully.
Numbers peaked 2013-2014 with 8k after recession.
Bove - Ongoing opiate crisis creates complications. Would like to see opiate funds disbursed for assistance.

Councilor Phillips - Asking for update of the 96 unit building.
Cullen- In process of redeveloping Mercy Hospital campus, older in one building and families in other totaling 95 Units. 45 units at Phoenix Flats - moved 22 homeless individuals into housing. 66 units opened in Bangor.
Emergency Shelter Committee meets 1x month and follows needs/trends.

Councilor Phillips -What is the progression to get into housing? Myth is tent to shelter to housing?

Bove- There are housing navigation services primarily located at the shelter, but does expand beyond (ie lowes encampment) just not as extensive.

Doherty- The tenting community can move around making it harder to access, its more efficient to work from the shelter capacity.

Cullen - March 2023 to Dec 2023 didn't move many. Once we moved people into shelter in December, numbers went up to a true housing move.

Councillor Fournier - Early intervention system/specialists leads to better level of care.

Question- As City Partners are there any things that we can do to support this work with the goal of getting people inside and sustained?

Doherty - Opioid settlement fund and distribution are a need.
Zoning is an issue - open (increase) where housing can go.
Perks of staff having great working relationships with each other.
Supporting critical programs that allow people to flourish.
Flex HSC - and reduce the turn away.

Cullen- The city has excellent strategies, keep it up.
Reinforce to flex capacity.
Trust and empower staff.
Trust community collaborative partners.
We do best when we treat people with dignity and respect.
January zero overdose is correlated to good housing, reduce stress = successful program

Bove- Try to get opiate funds dispensed asap.
Maintain shelter capacity.
Reduce stigma to unhoused and providers to gain community support.

5. Warmer Weather and Addressing Tents

6. NLC (National League of Cities) Conference

a. **Learning points from NLC conference**
Will shelve for the night and send memo out for April meeting.

Councilor Fournier - Will end with as warmer weather comes the tents/ shelters are beginning to pop up, as a committee how can we get ahead of this? What preventive measures are we doing, and where can we go next?

Shaza - HHS is trying to develop coordination in regards to outreach.
Reinforce beds are available at HSC.

Dena- City will continue to enforce ordinance that effectively prohibit camping.
When shelters are at capacity, the enforcement is lessened unless the encampment is creating a danger/ hazard.
Currently with openings at HSC enforcements are in place.

Chief Gautreau- (Add policy as backup material for encampments)
Tent removal has been minimal - enforcing policy is best approach currently

Councilor Fournier - Any sense of if people setting up tents are leaving shelter or new to the city?

Shaza - 2023 year in review report reads 24 % are chronically homeless.

Councilor Rodriguez - Folks being removed, are they the same individuals?
Chief Gautreau to check with Chief Dubois to get stats from Community Policing

Will keep tents as recurring agenda item

7. Next Meeting: April 9, 2024

The meeting adjourned at approximately 7:23 PM.

Health and Human Services & Public Safety Council Committee

2024 Committee Work Plan Draft

Committee Agreements

Our agreements are how we plan to work together as a committee in collaboration with staff and the community. I want to offer the agreements that we use in our gatherings and training in my work. The work that we do on this committee is critical to advancing important actions for our community. This takes all of us and the lived experience and knowledge we each carry.

- Be present.
- Take space, make space.
- Community care.
- Practice active listening.
- Assume good intentions.
- Zero tolerance for hate, discrimination, or prejudice.
- Challenge conventional wisdom.
- Have joy, have fun.

Goal Setting 2024 & Committee Work Plan Development

- Goal Pillars
    - Public Health
    - Human Services
    - Public Safety
    - Staff Priorities

Goal Setting 2024 & Committee Work Plan Development

- **First Quarter**
    - **HHS Year in Review**
    - **PD & FD Year in Review**
    - **Warming Shelter Updates**
    - **Homelessness & Housing Provider Panel**
- **Second Quarter (to be reviewed and detail added in March 2024)**
    - **Warmer Weather/Camping Policy**
        - **HOPE Team**
        - **ECRT Team**
    - **Anti-Cruising Ordinance Review**
    - **HSC Capacity**
        - **Asylee Shelter**

        - **Family Shelter**
    - **Opioid Settlement Discussion & Planning**
    - **Cooling Shelter Planning**
- **Third Quarter (to be reviewed and detail added in June 2024)**
    - **Warming Shelter Planning**
    - **Opioid Settlement Discussion & Planning (Public Hearing)**
    - **Asylee/New Mainer Office (State Support for Asylee arrivals)**
    - **HSC Updates**
    - **ESAC updates?**
- **Fourth Quarter (to be reviewed and detail added in September 2024)**
    - **Warming Shelter Implementation**
    - **Asylee/New Mainer Office (State Support for Asylee arrivals)**
    - **HSC Updates**

Staff priorities can be advanced at any time.

City of Portland | Executive Department
Danielle P. West, *City Manager*

To: Councilor April Fournier, Chair, and Members of the Health and Human Services & Public Safety Committee
From: Danielle P. West, City Manager
Date: April 22, 2024
Re: Opioid Settlement Funds Update

In September 2017, the Portland City Council passed Resolve 2, authorizing the City to join a nationwide lawsuit against opioid manufacturers. The resolution acknowledged the City's significant reallocation of resources to combat the epidemic, citing an increased investment in law enforcement, emergency responders, and social services. The lawsuit was intended to help pay for the social costs of the massive damages caused by the opioid epidemic.

This memo is intended to update the Committee regarding the proposed uses and processes related to the distribution of funds received as part of national settlements.

Opioid Settlement Funds: Receipts and Projections

Distribution of settlement funds will occur over 18 years, starting in 2022. Through March 1 2023, the City of Portland had received $747,067.56 of settlement payments. This funding has not yet been accepted or appropriated by the City Council.

The average annual amount projected to be received between FY25 and FY39 is estimated at approximately $235,000. The actual amount will fluctuate significantly year over year, due to the different payout periods agreed to in the various settlements.

In the coming months, information related to the receipt and allocation of funds, settlement schedules, eligible uses, and other important information will be published on the City website.

Allocation Process and Recommendation

Resolve 2-17/18 (attached) acknowledged that, "to treat and abate the opioid epidemic, the City has needed to shift resources that could have otherwise been used for various improvements and the general betterment of the City." At the time of the resolution's passage, it was intended that settlement funds would be used to pay for many of those treatment and abatement efforts, freeing up municipal revenue for other public improvements.

With this in mind, staff are developing recommendations for the allocation of already-received funding. These recommendations are expected to be ready for the Committee's consideration in July 2024. (For a list of eligible abatement strategies, see attached Exhibit E.) Staff recommendations may also anticipate sustaining new expenses over the next few years.

Staff recommend that the Committee also solicit additional recommendations from community members and/or partners in a public meeting. Based on staff suggestions, community input, and Committee guidance, staff will finalize a list of recommended expenditures to be ultimately reviewed and approved by the Committee and City Council.

Staff recommend that this or a similar process be implemented in each of the subsequent fiscal years until the funds have been fully disbursed.

Resolve 2-17/18
Passage: 9-0 on 9/18/2017 Effective 9/28/2017

ETHAN K. STRIMLING (MAYOR)
BELINDA S. RAY (1)
SPENCER R. THIBODEAU (2)
BRIAN E. BATSON (3)
JUSTIN COSTA (4)

CITY OF PORTLAND
IN THE CITY COUNCIL

DAVID H. BRENERMAN (5)
JILL C. DUSON (A/L)
PIOUS ALI (A/L)
NICHOLAS M. MAVODONES, JR (A/L)

RESOLUTION AUTHORIZING THE CITY TO JOIN A LAWSUIT AGAINST OPIATE DRUG COMPANIES

WHEREAS, the City Council of Portland, Maine, has learned to its sorrow over the last several years exactly how devastated many of its residents have become because of addictions to painkillers manufactured by drug companies; and

WHEREAS, officers working for the Portland Police Department, Fire Department and several other City Departments are required to respond every day to problems that arise because of addiction to painkillers; and

WHEREAS, to treat and abate the opioid epidemic, the City has needed to shift resources that could have otherwise been used for various improvements and the general betterment of the City; and

WHEREAS, employees in the Social Services Division who manage the City's homeless shelters work with many homeless people who suffer from drug addiction to painkillers and who struggle to care for themselves; and

WHEREAS, approximately 80 percent of people who use heroin have been prescribed opiates in the past; and

WHEREAS, in 2016, 376 people died in the State of Maine from drug overdoses, and 123 of those deaths were caused by pharmaceutical opioids; and

WHEREAS, 42 people died of drug overdoses in the City of Portland in 2016; and

WHEREAS, the ease with which these drugs have been obtained, as a result of drug companies' campaign to make them readily prescribed for common aches and pains, has led many people to become addicted; and

WHEREAS, opiate drug companies have enjoyed enormous profits with the sales of opiate drugs, promoting them relentlessly among physicians and paying doctors to promote these drugs at conferences, while failing repeatedly to successfully tailor the drugs to make abuse impossible;

NOW, THEREFORE, BE IT RESOLVED, that the Portland City Council and Mayor hereby authorize Corporation Counsel Danielle West-Chuhta to engage the services of Napoli Shkolnik, PLLC and Trafton, Matzen, Belleau & Frenette, LLP on behalf of the City of Portland with respect to prosecution of any legal claims against manufacturers and distributors of opioids arising out of the manufacturers' and distributors' fraudulent and negligent marketing and distribution of opioids.

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

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

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

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

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

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

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

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

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

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

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

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

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

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

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

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

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

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

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

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

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

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

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

F. **TREATMENT FOR INCARCERATED POPULATION**

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

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

G. **PREVENTION PROGRAMS**

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

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

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

4. Funding for community drug disposal programs; and

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

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

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

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

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

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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