**Remote HHS and Public Safety Committee Agenda**
June 11, 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).

The Health & Human Services and Public Safety Committee will conduct this meeting remotely via Zoom pursuant to the Remote Meeting Policy adopted by the Portland City Council. Allow your computer to install the free Zoom app to get the best meeting experience. If you are not able to attend live either in person or via Zoom, a recording will be available in the Agenda Center following the meeting.

You are invited to a Zoom webinar.
When: Jun 11, 2024 05:30 PM Eastern Time (US and Canada)
Topic: Remote HHS and Public Safety Meeting

Please click the link below to join the webinar:
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Or One tap mobile :
+13017158592,,85713124458#,,,,*834261# US (Washington DC)
+13052241968,,85713124458#,,,,*834261# US
Or Telephone:
Dial(for higher quality, dial a number based on your current location):
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 646 931 3860 US
+1 929 205 6099 US (New York)
+1 564 217 2000 US
+1 669 444 9171 US
+1 669 900 6833 US (San Jose)
+1 689 278 1000 US
+1 719 359 4580 US
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+1 253 215 8782 US (Tacoma)
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+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
Webinar ID: 857 1312 4458

Passcode: 834261
International numbers available: https://portlandmaine-gov.zoom.us/u/kbo9fApBOW

1. Announcements

2. Review and Approval of Minutes from May 14, 2024

   a. May Minutes

3. Public Hearing: Repeal of Section 17.5 of City Code (re: Cruising)
   *Public comment will be accepted prior to the Committee's consideration of the item at hand.*

   a. Staff Memo
   b. City Code 17.5

4. Cooling Shelter Update (Caity Hager, Emergency Management Coordinator)
   *Staff will provide an update on the process by which cooling shelters are established by the City of Portland.*

5. Bayside Update (Chief Mark Dubois, Police Department)
   *Staff will provide an update on enforcement operations and calls for service in the Bayside neighborhood.*

6. Discussion: Syringe Service Program (Councilor April Fournier, Chair)
   *By request of Mayor Mark Dion, the Committee will receive and discuss information related to the administration of the City of Portland's Syringe Service Program.*

   a. Staff Memo

7. Opioid Abatement Strategies Landscape: Panel Discussion (Councilor April Fournier, Chair)
   *By request of the Committee and to inform future allocations of opioid settlement funds, representatives from Milestone, The Opportunity Alliance, Spurwink, Commonspace, and Maine Health will share insight on the services and programs they provide, related to opioid abatement strategies.*

   a. Staff Memo

8. Next Meeting: July 9, 2024

**Tuesday, May 14, 2024, 5:30pm, Remote Meeting**

Committee Attendance:

April Fournier, Chair (At-large), Anna Trevorrow (District 1), Roberto Rodriguez (At-Large).

City Staff:

Jessie Lemieux, Executive Assistant for Fire Department; Counsel; Keith Gautreau, Fire Chief; Dan Hondo, Police Major; Dena Libner, Assistant City Manager/Interim Director of HHS; Greg Jordan, Assistant City Manager.

1. Announcements:

2. Review and Approval of Minutes from April 23,2024

   Minutes approved by Rodriguez and Trevorrow
   Approved unanimously

3. Repeal of Section 17.5 of City Code (re: Cruising) (Councilor Fournier, Chair)

This request was brought forward from the public. Code was enacted in the 90s, and was designed to prevent solicitation but inadvertently targeted the gay community.

Greg Jordan - Police Chief and staff looked over code to review its use. No fiscal impact if removed. There is no evidence suggesting it targeted any particular group, but understand the perception.

Major Hondo - This memo was used for the assistance in deterring prostitution in hot spots, but use is infrequent and possibly outdated now and there are other ways we can use our resources.. Based on conclusions it would not create an issue if gone, but we (PD) would lose an investigative technique which can be helpful to us in some cases.

Councilor Rodriguez - Memo is helpful, will be supporting repeal. When people are looking for parking/ lingering and circle blocks, does this fall under code?

Major Hondo - Does not fall under this code. Hard to say if environmental changes in hotpots like good lighting, more sidewalks, more resources would deter this activity vs keeping code and citing, because it is so mobile by the transient community.

Councilor Fournier - Does support removal, but leaning in the direction of having a public meeting/hearing in June meeting list as an action item to allow public comment.

4. Staff Updates

   1.) Planning Board application for Homeless Services Center site plan amendment (Dena Libner, Assistant City Manager)

   Staff has submitted an application for the permanent increase at 654 Riverside St (HSC) by 50 beds
   May 28 to the planning board, and 45 days after consideration go into effect
   Public can weigh in at Planning Board meeting

   2.) Opioid Settlement Fund allocation process update (Dena Libner, Assistant City Manager)

   Tentatively in July, (looking at effective opioid strategies) looking at ways to use the funds. Looking at what the Maine Recovery Council is doing, also have a public facing website before the June meeting this will go live and then we can discuss on our end.

Councilor Fournier - Going into warmer days, thinking about cooling shelters
   Chief Gautreau - will present plan in June, bringing Caity Hager into the conversation

Discussion on the conditions in Bayside and any updates:
   Major Hondo - Changes made are more consistency in the bayside area, more officer presence. Greater update next month

Dena Libner - staff is working on a memo on needle exchanges and sharps containers.
   This is open to staff questions and suggestions.

   Meeting adjourned at approximately 5:55pm

5. Next Meeting: June 11, 2024

**City of Portland | Police Department**
Mark Dubois, *Police Chief*

**Staff Memo To:**
Health and Human Services & Public Safety Committee,
Councilor April Fournier, Chair

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**MEETING DATE**
June 12, 2024

**AGENDA ITEM**
Agenda Item # 3 - Repeal of Portland City Code Section 17-5

**PURPOSE**
The committee requested a staff assessment of repealing Section 17-5 of the Portland City Code. This item was previously reviewed by the committee at its May 14, 2024 meeting. Public comment will be taken prior to a committee vote to submit this to the City Council for consideration.

**COMMITTEE WORK PLAN/CITY COUNCIL GOAL ALIGNMENT**
This item is identified in the HHS-PS Committee's 2024 work plan as amended on April 23, 2024.

**BACKGROUND/ANALYSIS**
To ensure a complete discussion about rescinding the Cruising Ordinance, please consider the following information regarding the actual use of the ordinance, and the impact rescinding it will have.

A search for violations of Portland City Code Sec. 17-5 was performed at my request. In the Police Department's current Records Management System (ProPhoenix) of records since 2021, there was one (1) recorded violation in 2023, and that subject went to court and paid the fine. A check of our prior Records Management System documented ten (10) unlawful cruising citations issued. All of these citations were issued for solicitation of prostitution where a female was propositioned by a male in a motor vehicle. Four (4) of the citations were from 1998 and 1999. One (1) citation took place in Bayside at Preble St in 2015 and five (5) more from the Walker St / Congress St area, four (4) between 2015-2017, and most recently, one (1) citation issued in 2021.

I discussed the history of enforcement of this ordinance with Acting Assistant Chief Martin, who has been with the Department for almost 38 years. He recalled that the original intent of the code provision was to address prostitution to deter males soliciting, and that it was not specifically designed to target homosexual males. This ordinance has also been useful for

officers in our Crime Reduction Unit (CRU) in investigating illegal drug sales, many of which take place from vehicles. Because it is an ordinance (and not a criminal statute), our Neighborhood Prosecutor, Richard Bianculli, prosecutes any violations, and the only punishment allowable by law is a fine, not jail.

According to Attorney Bianculli, the ordinance is used very infrequently. In his 8 years as the Neighborhood Prosecutor he has only encountered reports involving males soliciting female prostitutes. His most recent violation involved a male who paid the fine and admitted to soliciting a female prostitute. Additionally, we often receive complaints of women who are not prostitutes being solicited from vehicles while in the Walker Street area, many of whom are Maine Medical Center employees. Most recently, we had a male circling City Hall apparently soliciting people in the area.

There are no practical alternatives to allow us to issue a civil penalty. The only option would be a criminal summons, which would require more aggressive behavior towards a victim before we could enforce.

**FISCAL IMPACT**
Given the infrequent application of this ordinance, the loss of civil penalty fines is anticipated to be very small and will not materially impact the city's budget.

**CONCLUSION(S)**
Section 17-5 of the Portland City Code provides a tool for the Police Department to intervene and prevent instances of commercial sexual exploitation, and conduct investigations of illegal drug sales. There are no indications the ordinance is used to target any particular demographic group(s). However, the ordinance is infrequently used and staff do not believe its repeal would adversely impact public safety.

**PRIOR COMMITTEE REVIEW**
Health and Human Services & Public Safety Committee - April 23, 2024
Health and Human Services & Public Safety Committee - May 14, 2024

**PREPARED BY**

Mark Dubois
Chief of Police
Police Department

Greg Jordan
Assistant City Manager
Executive Department

**ATTACHMENTS**
Attachment A - Portland City Code, Section 17-5

**Sec. 17-5. Cruising.**

(a) No person shall drive or permit a motor vehicle under that person's care, custody, or control to be driven past a traffic-control point three (3) times within a two-hour period in or around a posted "no cruising" area.

(b) Every "no cruising" area shall be posted with signs to provide notice of the prohibition which shall state the following: "No Cruising. No person shall drive or permit a motor vehicle under that person's care, custody, or control to be driven past a traffic-control point three (3) times within a two-hour period in this area."

(c) A traffic-control point as used in this section means a reference point selected by a police officer within or adjacent to a designated "no cruising" area for the purpose of determining cruising.

(d) No area shall be designated or posted as a "no cruising" area except following such a designation upon order of the traffic engineer following a request from the police department.

(e) The following shall be exempted from the provisions of this section:

(1) Any publicly owned vehicle of any city, county, state or federal, or any governmental unit, while the vehicle is





being operated for the official purposes of the governmental unit;

(2) Any authorized emergency vehicle;

(3) Any taxicabs for hire, public transit buses, livery, or other vehicles being operated for business purposes.

(f) Whoever violates any of the provisions of this section shall be punished by a minimum fine of one hundred dollars ($100.00) for the first offense; a minimum fine of three hundred dollars ($300.00) for a second offense; and a minimum fine of five hundred dollars ($500.00) for each and every offense thereafter. In any action in which the city prevails, it shall be entitled to attorneys' fees and all costs of prosecution.

(g) Subsection (f) notwithstanding, prior to citing the owner or operator of a vehicle for a violation of this section, the police department may give a written notice to the person operating the vehicle in violation of this section at the time of the violation informing that person of the use of the vehicle in violation of this section.

**City of Portland | Health & Human Services Department**
Dena Libner, *Assistant City Manager / Interim Director*

**Staff Memo To:**
Health and Human Services & Public Safety Committee
Councilor April Fournier, Chair

**DATE**
June 10, 2024

**AGENDA ITEM**
Agenda Item #6 - Syringe Service Program (SSP) Operations

**PURPOSE**
In response to public concern re: syringes observed on public and private property, the Committee requested information on the distribution and collection of syringes in the City of Portland.

No policy action is proposed at this time.

**COMMITTEE WORK PLAN ALIGNMENT**
While the Committee's 2024 work plan does not include consideration of policies specific to syringe exchange, related topics, such as chronic homelessness and opioid settlement funds, have been or are scheduled for discussion over the course of the calendar year.

**BACKGROUND/ANALYSIS**
The City of Portland's syringe services program (SSP) is part of the City's suite of harm reduction services[1], collectively referred to as "The Exchange". Harm reduction is an evidence-based strategy to engage with people who use drugs, equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives. Harm reduction is a key pillar in the U.S. Department of Health and Human Services' Overdose Prevention Strategy.

The City of Portland's SSP is based out of 39 Forest Avenue. In addition, staff also provide harm reduction services at up to eight on-street locations, as certified by the Maine Center for Disease Control & Prevention (MeCDC). These services include syringe distribution, health education, wound care, and service referrals to various resources and providers.

[1] The Exchange provides a number of other harm reduction services, including but not limited to Hepatitis A/B vaccinations, HIV/HCV testing, and general medical referrals.

The City of Portland's SSP is one of only two SSPs in Cumberland County; as such, people from throughout the region travel to Portland for harm reduction and supply services, including sterile syringes.

The City of Portland's SSP is primarily funded, certified, and regulated by MeCDC. According to that office's rules, "[p]programs must adhere to a distribution policy that allows the one-for-one exchange of a used syringe for each new syringe provided to the Consumer. In instances where the Consumer cannot offer a used syringe to be exchanged, a Program may provide a Consumer with new syringes as needed, but may not exceed 100 syringes per Consumer per encounter" (22 MRS ch. 252-A §1341, https://www.maine.gov/sos/cec/rules/10/144/144c252.docx).

Collection of used syringes is also an important part of the City's harm reduction services, as well as its regular maintenance of public property. Collection services occur at nearly 50 locations throughout the City (see attachments). These containers are emptied regularly by Public Health or Parks staff.

Specially-trained Public Works and Parks staff also collect syringes observed by themselves or members of the public on public property, including parks, plazas, streets, and sidewalks. If a member of the public observes a syringe on public property, they are encouraged to submit a request through See Click Fix (https://seeclickfix.com/portland_2) or call 207-874-8493 so that a trained specialist can be dispatched to collect and properly dispose of the items.

The numbers of syringes distributed and collected have changed significantly over the last four years (Table 1), which reflect the implementation of changes in State policy in response to the coronavirus pandemic:

- **Pre-pandemic:** State policy limited syringe distribution to a 1:1 exchange ratio.
- **March 2020:** SSPs are now allowed to distribute up to 10 syringes per client, and the exchange requirement was lifted.
- **April 2021:** SSPs are now allowed to distribute up to 50 syringes per client.
- **August 2021:** The pre-pandemic 1:1 exchange ratio was reinstated after the Governor's State of Emergency ended.
- **September 2022:** MeCDC issued a rule change that removed the exchange requirement and allowed SSPs to distribute up to 100 syringes per client. This policy change reflects evidence-based best practices[2] in harm reduction.

[2] According to the National Institutes of Health, which is part of the United States Department of Health and Human Services, "Most effective programs offer on-demand sterile supplies without restrictions or requirements to return used syringes."
https://nida.nih.gov/research-topics/syringe-services-programs#how-do-syringe

| | 2019 | 2020[A] | 2021 | 2022 | 2023 | 2024 YTD[B] |
|---|---|---|---|---|---|---|
| Unique Clients | 852 | 432 | 1,373 | 1,874 (36%) | 2,361 (26%) | 1,074 |
| Syringes Distributed | 222,977 | 303,974 (36%) | 402,369 (32%) | 736,904 (83%) | 806,951 (10%) | 257,902 |
| Syringes Collected[C] | 269,417 | 261,260 (-3%) | 394,998 (51%) | 718,726 (82%) | 574,126 (-20%) | 182,979 |

***Table 1:*** *Syringe distribution and collection activity over time, including percentage change year over year. Activity reflects City of Portland operations and does not include activity conducted by Commonspace or other syringe services programs.*

[A]*Commonspace began operating its SSP in November 2020. This, along with State policy changes, are among the contributing factors for the increase in syringe distribution over time.*

[B]*2024 data includes clients and syringes from January 1, 2024 to May 5, 2024.*

[C]*Includes all properly- and improperly-disposed syringes collected by City of Portland staff.*

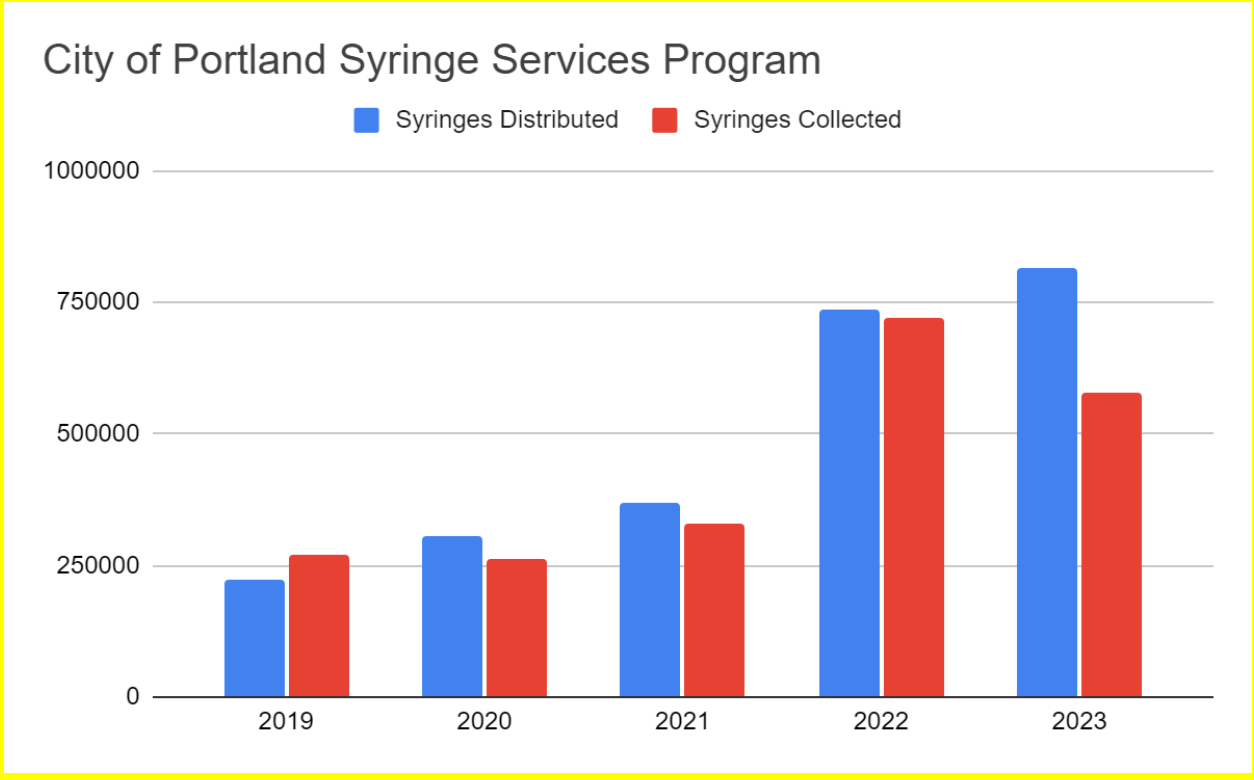



***Chart 1:*** *Visualization of data presented in Table 1. Changes in the number of distributed syringes reflect the implementation of policy changes by the State of Maine.*

Since 2020, the City of Portland has collected fewer syringes than it distributes (Chart 1). However, that does not necessarily mean that the syringes collected by the City of Portland are ones staff distributed, or that those we distributed and did not collect were improperly disposed of. For example, some SSP clients live in other Maine towns or cities; due to the

distance of their home from Portland, they may request a higher number of clean syringes than a Portland resident would, eventually discarding them closer to home.

**FISCAL IMPACT**
N/A (while the regular exchange and collection of syringes is associated with recurring operational expenses, this memo does not contemplate the addition of new operational requirements or expenses).

**CONCLUSIONS(S)**
N/A (this memo does not include an evaluation of new policy proposals).

**PRIOR COMMITTEE REVIEW**
The 2024 HHS & PS Committee has not discussed this matter prior to the June 11, 2024 meeting.

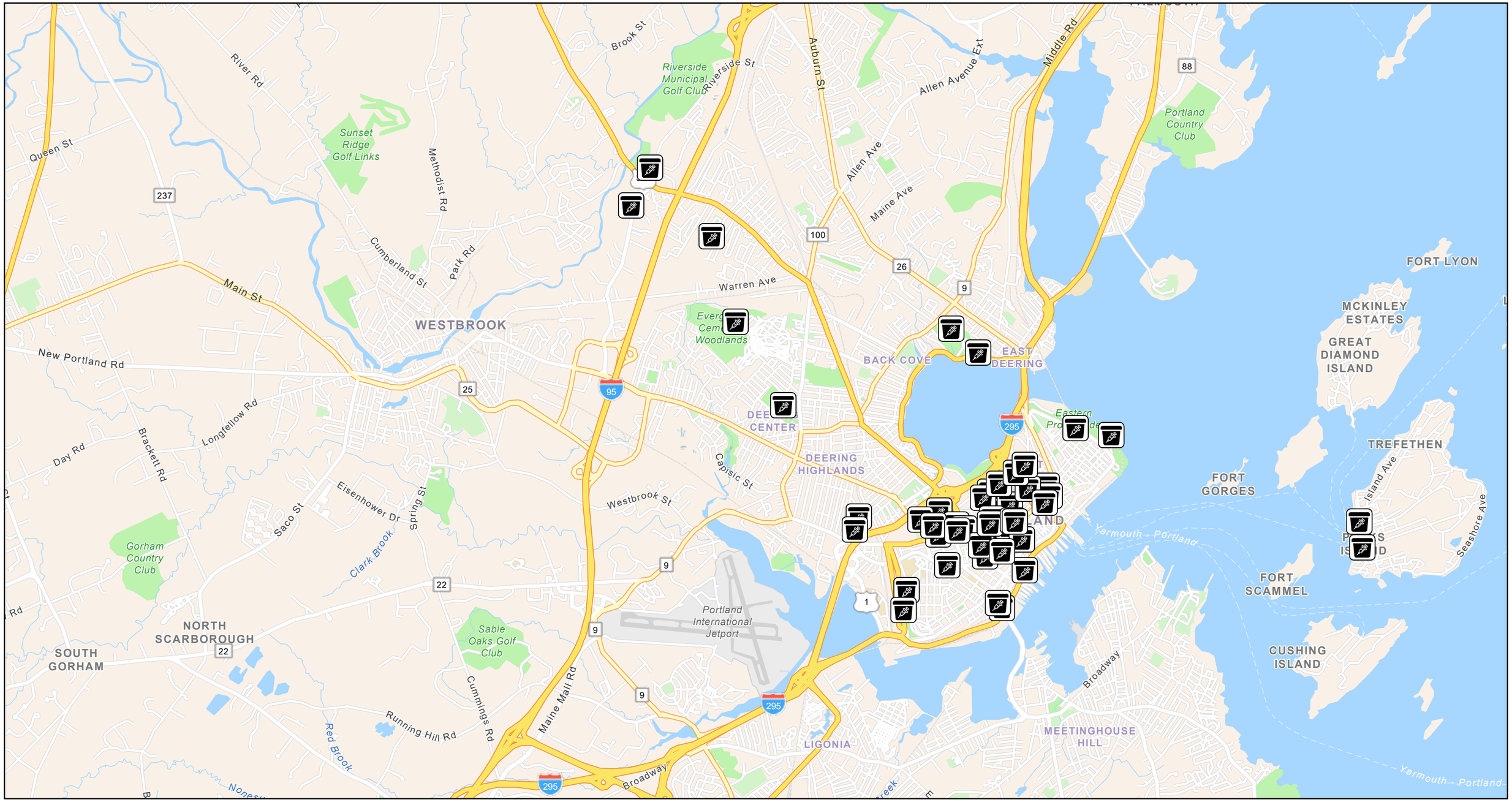
**PREPARED BY**

Dena Libner
Assistant City Manager
Executive Department

Alfredo Vergara, PhD
Director, Public Health Division
Department of Health and Human Services

**ATTACHMENTS**
List - Locations of City of Portland Sharps Containers (June 2024)
Map -Locations of City of Portland Sharps Containers (June 2024)

# City of Portland Sharps Containers




6/7/2024, 1:46:40 PM

Sharps Containers View Layer

1:72,224

0 0.5 1 2 mi

0 1 2 4 km

Esri, TomTom, Garmin, SafeGraph, GeoTechnologies, Inc, METI/NASA, USGS, EPA, NPS, USDA, USFWS

| | Location List of Sharps Containers |
|---|---|
| 1 | Peppermint Park (back of big belly trash can) |
| 2 | East End Beach (bathroom area, telephone pole) |
| 3 | Chestnut Street Community Garden (on shed) |
| 4 | Bayside Trail on Chestnut Street (big belly trash can) |
| 5 | Bayside Trail (stone circle, blue light pole) |
| 6 | Bayside Trail (behind Dunkin' Donuts on blue light pole) |
| 7 | Stone St. Playground (big belly trash can) |
| 8 | Spring Street Garage (men's and women's bathrooms) |
| 9 | Congress Square Park (light pole) |
| 10 | Harbor View Park (middle section down the path - light pole) |
| 11 | Western Prom (at the turn off, big belly trash can) |
| 12 | Deering Oaks (between baseball field and playground - big belly tras |
| 13 | Deering Oaks (bridge over kiddie pool - big belly trash can) |
| 14 | Deering Oaks (porta potties, fence on the back) |
| 15 | Deering Oaks (Mellen Street sidewalk - on telephone pole) |
| 16 | Deering Oaks (Rose Circle - light pole in the middle) |
| 17 | Edwards Lot (off of High Street, on sign post) |
| 18 | Dougherty Field (vault toilet next to skatepark) |
| 19 | Dougherty Field (path / skatepark) |
| 20 | Payson Park Vault Toilet 1 (at Baxter Boulevard) |
| 21 | Payson Park Basketball Court Vault Toilet |
| 22 | Boyd Street Garden (shed) |
| 23 | Fox Field (basketball court, inside outdoor restroom) |
| 24 | First Parish / Freshman Alley 1 |
| 25 | First Parish / Freshman Alley 2 |
| 26 | HSC Trailhead |
| 27 | Fox/North Boyd Street |
| 28 | 103 India Street |
| 29 | 290 Congress Street - Portland Food Co-op (inside) |
| 30 | Corner of Oxford and Preble Streets |
| 31 | Corner of Portland and Alder Streets |
| 32 | Preble Street - Portland Public Market |
| 33 | Portland Public Library Fence 1 |
| 34 | Portland Public Library Fence 2 |
| 35 | First Parish - 425 Congress Street |
| 36 | The Exchange - 39 Forest Ave |
| 37 | Intersection of Congress/Mellen Streets |
| 38 | Valley Street Dog Park |
| 39 | Commercial Street/Fish Pier |
| 40 | Harborview Park - Tyng/State Street Entrance |
| 41 | Eastern Prom (basketball court, inside outdoor restroom) |
| 42 | Restroom Facility at Spring/Cross |
| 43 | Evergreen Cemetery Vault Toilet |
| 44 | Park Ave, Deering Oaks rose circle, inside outdoor restroom |
| 45 | Peaks Island Community Center, toilet |
| 46 | Peaks Island Ferry Parking Lot, toilet |
| 47 | Riverton Trolley Park Vault Toilet |
| 48 | Riverton Community Center / Garden Vault Toilet |
| 49 | Deering High School Parking Lot Vault Toilet |

**City of Portland | Health & Human Services Department**
Dena Libner, *Assistant City Manager / Interim Director*

**Staff Memo To:**
Health and Human Services & Public Safety Committee
Councilor April Fournier, Chair

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**DATE**
June 10, 2024

**AGENDA ITEM**
Agenda Item #7 – City of Portland Core Opioid Abatement Strategies

**PURPOSE**
This memo serves as an assessment of existing City activities that fall within core opioid abatement strategies, and is intended to support the Committee's discussion of programs and services provided by private partners.

No policy action is proposed at this time.

**COMMITTEE WORK PLAN/COUNCIL GOAL ALIGNMENT**
The Committee's 2024 work plan includes discussion and planning for the City's opioid settlement funding.

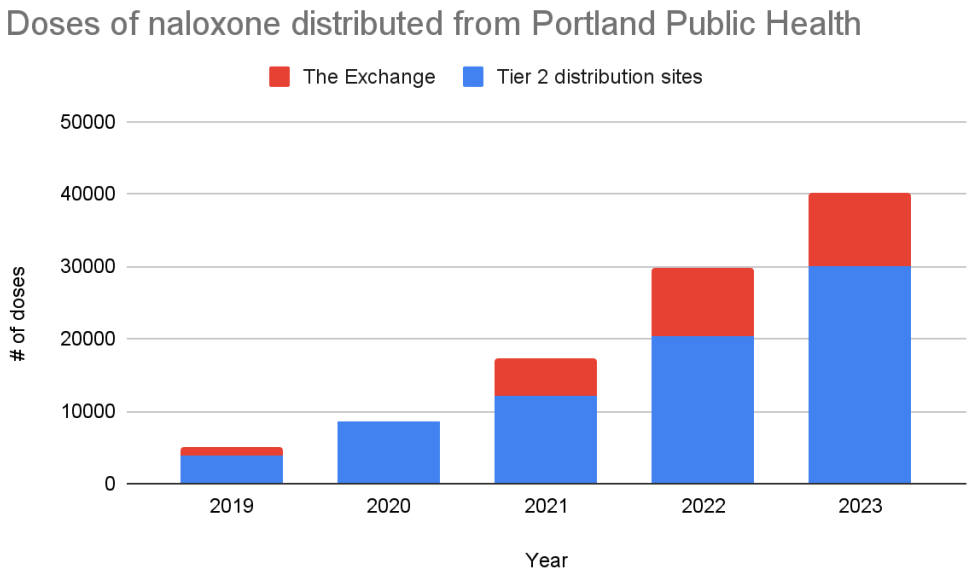
**BACKGROUND/ANALYSIS**
According to the national opioid settlements, at least 85% of funds should go directly to the abatement of the opioid epidemic. Opioid settlement remediation uses have been outlined as the 'core strategies' (see Exhibit E) and provide a framework for state and local consideration.

The following are existing City of Portland services and programs that are considered to be core abatement strategies, as defined in the settlements..

**Naloxone or other FDA approved drugs to reverse opioid overdoses**
Naloxone has been administered by City of Portland EMS personnel for decades. Starting in 2015, however, broad distribution of naloxone by City of Portland staff has been fundamental to the City's abatement efforts.

Naloxone is regularly used in emergency situations by staff at the Homeless Services Center (HSC), as well as by various emergency responders and service providers (Fire Department, its Mobile Medical Outreach unit (MMO), and Police Department). All HSC staff and emergency responders are trained in its usage.

In addition, the City of Portland's Public Health Division distributes naloxone to clients as well as secondary ("Tier 2") providers throughout Cumberland and York counties as part of its harm reduction program ("The Exchange"). As a result of increased year-over-year funding and the Division's regional leadership, nasal Narcan is now widely available in southern Maine (see chart below).




**Medication assisted treatment (MAT) and other opioid related treatment**
The City of Portland connects clients at the HSC with MAT in several ways:

- Treatment using Suboxone and Sublocade is directly provided to clients at the HSC through an onsite partner (The Greater Portland Health Clinic).
- Transportation to an offsite treatment center is provided twice daily for guests receiving methadone treatment by a private partner (Milestone's HOME Team).
- Private partners provide weekly onsite recovery support groups to those in MAT as well as virtual support services are offered to HSC guests by Groups Recover Together and Better Life Partners.

**Pregnant & postpartum women**
The City of Portland (Fire, MMO, and Public Health) has contracted with MaineMOM, a program of MaineHealth, to provide services to difficult-to-reach pregnant and postpartum women.

This collaboration, established in January 2024, allows bi-directional communication between medical providers and community-based paramedics.

**Warm hand-off programs and recovery services/Connections to Care**
City of Portland staff work closely across departments and with private partners to provide service referrals and warm handoffs as often as possible. That work is led by several City departments/divisions, including Social Services' Outreach and Engagement team, wraparound services provided onsite at the Homeless Services Center, the Public Health Clinic, Mobile Medical Outreach, and the Police Department's Behavioral Health response team.

Numerous referrals are made for housing, healthcare, treatment, and other services that promote a path to self-sufficiency.

**Prevention programs**
The Public Health Division's Substance Use Prevention Services (SUPS) works to prevent or delay the initiation of substance use in our youth and young adults ages 12-24. The Prevention Team has one staff member dedicated to SUPS.

The SUPS program's opioid-specific work has been fairly lean in the past year and a half due to funding constraints; as a result, the work has primarily focused on preventing "prescription drug misuse." However, the overarching goal of substance use prevention programming is to support youth and young adults in building community, increasing protective factors, and reducing adverse childhood experiences, which are linked to future use of opioids and opioid use disorder.

**Syringe services programs**
The Public Health Division operates a syringe service program at 39 Forest Ave., which is certified and funded by the Maine CDC. Its team of trained harm reductionists connect clients with overdose prevention supplies and services, typically serving between 150-200 individuals each week.

**Data collection and research analyzing the effectiveness of abatement strategies**
In August 2023, the Public Health Division received a five-year, $4 million grant from the Federal CDC's Overdose Data 2 Action- Local program (OD2A - local) to increase staffing, infrastructure and reach of abatement services throughout Cumberland County. One of the main objectives of the OD2A grant is to help build a tracking system of the City's progress in preventing opioid overdoses and providing services that help People Who Use Drugs (PWUD) successfully enter into treatment and find the stability needed to recover.

In addition, this funding will help evaluate and inform the implementation of City of Portland harm reduction programs. For example, mapping overdoses will allow staff to identify trends and more strategically allocate resources.

**CONCLUSIONS(S)**
N/A (this memo does not include an evaluation of new policy proposals).

**PRIOR COMMITTEE REVIEW**
The HHS & PS Committee has not discussed this matter prior to the June 11, 2024 meeting.

**PREPARED BY**

| | | |
|---|---|---|
| Dena Libner<br>Assistant City Manager<br>Executive Department | Shaza Stevenson<br>Deputy Director<br>Department of Health and Human Services | Alfredo Vergara<br>Public Health Director<br>Department of Health and Human Services |

**ATTACHMENTS**
Exhibit E (List of Opioid Remediation Uses - Core Strategies)

# 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.