

Exhibit L

TEVA NEW YORK PREMIUM PAYMENT OPIOID SETTLEMENT SHARING AGREEMENT

This Agreement sets forth the terms and conditions governing the sharing and allocation of funds between and among the State of New York and the New York Subdivisions (as defined below) received from Teva (as defined below) under the Premium Payment Portion of the New York Teva Opioids Settlement Agreement (defined below), which constitutes a “Statewide Opioids Settlement Agreement” as defined in N.Y. Mental Hyg. Law § 25.18(a)(8);

Whereas, the people of the State of New York and its communities have been harmed by misfeasance, nonfeasance, and malfeasance committed by Teva;

Whereas, the State of New York and certain New York Subdivisions are engaged in litigation seeking to hold Teva accountable for the damage caused by their misfeasance, nonfeasance, and malfeasance; and

Whereas, the State of New York and the New York Subdivisions share a common desire to abate and alleviate the impacts of the misfeasance, nonfeasance, and malfeasance of Teva throughout the State of New York;

Now therefore, notwithstanding the New York Distributor Statewide Opioid Settlement Agreement, the New York Janssen Statewide Opioid Settlement Agreement, and the New York Allergan Statewide Opioid Settlement Agreement, the State of New York and the New York Subdivisions enter into this Agreement relating to the allocation, distribution, and use of the proceeds of the Premium Payment Portion of the New York Teva Opioids Settlement (as defined below).

I. DEFINITIONS

- A. “Approved Uses” means any opioid or substance use disorder related projects or programs that fall within the list of uses in Schedule D.
- B. “Lead State Agency” means the New York State Office of Addiction Services and Supports. As provided for in Section V, The Lead State Agency will coordinate with the New York Department of Health, the New York Office of Mental Health, and the New York Division of Housing and Community Renewal, as well as other agencies, to expend and oversee funds from the Teva Opioid Settlement Fund.
- C. The “Advisory Board” means the advisory board created and described by N.Y. Mental Hyg. Law § 25.18(c) and Section V of Exhibit N of the New York Distributor Statewide Opioid Settlement Agreement.
- D. “Direct Share Subdivision” means every county of the State of New York other than the County of Nassau, the County of Suffolk, and the City of New York.
- E. “Large New York Cities” means New York cities other than New York City with a 2020 population of more than 90,000 – *i.e.*, the cities of Albany, Buffalo, Rochester, Syracuse and Yonkers.
- F. “New York Allergan Statewide Opioid Settlement Agreement” means the Allergan New York Settlement Agreement, executed on December 8, 2021.

- G. “New York Distributor Statewide Opioid Settlement Agreement” means the Distributors New York Settlement Agreement, executed on July 20, 2021.
- H. “New York Janssen Statewide Opioid Settlement Agreement” means the Janssen New York Settlement Agreement, executed on June 25, 2021.
- I. “New York Subdivisions” means each county, city, town, village or special district in New York.
- J. “Opioid Settlement Funds” shall mean monetary amounts obtained through the Teva Opioid Settlement Agreement as defined in this Agreement.
- K. “Teva” shall mean (i) Teva Pharmaceutical Industries Ltd. and (ii) all of its respective past and present direct or indirect parents, subsidiaries, divisions, affiliates, joint ventures, predecessors, successors, assigns, including but not limited to Teva Pharmaceuticals USA, Inc., the Actavis Generic Entities, and Anda, Inc.
- L. The “Premium Payment Portion” means the amounts paid pursuant to Sections III.A.1.b of the New York Teva Opioids Settlement Agreement.
- M. “Parties” means the State of New York and the New York Subdivisions who execute this agreement.
- N. “New York Teva Opioids Settlement Agreement” shall mean this settlement agreement jointly entered into by the State of New York and New York Subdivisions with Teva.
- O. “Opioid Settlement Fund” means the fund created by Section IV, which will be used or distributed in accordance with Section IV and this Agreement.

II. GENERAL FINANCIAL AND STRUCTURE TERMS

- A. **Scope of Agreement.** This Agreement applies to the Premium Payment Portion of the New York Teva Opioids Settlement Agreement.
- B. **Allocation and Distribution of Funds for Restitution and Abatement.** Opioid Settlement Funds from the Premium Payment Portion of the New York Teva Opioids Settlement Agreement shall be allocated and distributed as follows:
1. **17.5%** to the State of New York (unless not in accordance with state law). The Office of the Attorney General shall have the discretion to allocate a portion of these funds to local governments not listed in the annexed allocation chart.
 2. **16.39%** to the Lead State Agency to be placed in the Opioid Settlement Fund for Regional Spending on Approved Uses. In combination, the amount of Regional Spending of the Opioid Settlement Fund committed to the Large New York Cities shall not be less than 1.89% of the total Opioid Settlement Funds and the amount of Regional Spending of the Opioid Settlement Fund committed to the other litigating municipalities listed in Schedule C shall not be less than 0.34% of the total Opioid Settlement Funds.
 3. **22.89%** to the Lead State Agency to be placed in the Opioid Settlement Fund for Discretionary Spending on Approved Uses and for Administration of the Opioid Settlement Fund.
 4. **7.98%** to the Direct Share Subdivisions as “Direct Unrestricted Funds”.

5. **9.75%** to the Direct Share Subdivisions for spending on Approved Uses (“Direct Restricted Funds”).
6. **0.69%** to the Large New York Cities for spending on Approved Uses (“Large New York Cities Restricted Funds”).
7. **24.80%** to the City of New York for spending on Approved Uses.

C. **Redistribution in Certain Situations.** In the event a New York Subdivision merges, dissolves, or ceases to exist, the allocation percentage for that New York Subdivision shall be redistributed equitably based on the composition of the successor New York Subdivision. If a New York Subdivision for any reason is excluded from a specific Settlement, including because it does not execute a release as required by Section III.A, the allocation percentage for that New York Subdivision pursuant to Sections II.B.4, 5 and/or 6 shall be redistributed equitably among the participating New York Subdivisions.

D. **Direct Payment of Certain Funds.** All Opioid Settlement Funds allocated to the Direct Share Subdivisions, the Large New York Cities and the City of New York pursuant to Sections II.B.4, 5, 6 and 7 shall be paid directly and as promptly as reasonably practicable by Teva or the settlement fund administrator(s) to the Direct Share Subdivisions, the Large New York Cities, and the City of New York.

III. THE DIRECT SHARE SUBDIVISION AND CITY OF NEW YORK FUNDS

Distribution of the Direct Share Subdivision Funds. The Direct Unrestricted Funds and the Direct Restricted Funds shall be paid to the Direct Share Subdivisions that execute a release for the New York Teva Opioid Settlement Agreement, pursuant to Section II.B.4 and 5, and will be fully distributed among them pursuant to the allocation set forth in Schedule A to this Agreement. The Large New York Cities Restricted Funds shall be paid to the Large New York Cities that execute a release for the New York Teva Opioid Settlement Agreement, pursuant to Section II.B.6 and will be fully distributed among them pursuant to the allocation set forth in Schedule B to this Agreement.

Certification of Spending on Approved Uses. Each year, the Direct Share Subdivisions and the City of New York shall certify to the Lead State Agency and the Advisory Board that all funds distributed to them pursuant to Sections II.B.5 and 6 of this Agreement as well as under the Teva New York Global Payment Opioid Settlement Sharing Agreement, which were spent during the preceding year, were spent on projects and programs that constitute Approved Uses. These certifications shall be made by August 1 of each year following the year in which such funds were spent and shall be accompanied by a detailed accounting of the spending of such funds as well as analysis and evaluation of the projects and programs they have funded.

IV. THE OPIOID SETTLEMENT FUND

A. Establishment of the Opioid Settlement Fund.

1. Each year the Lead State Agency will allocate approximately **45%** of the Opioid Settlement Fund (16.39% of the total Opioid Settlement Funds) for Approved Uses in the various regions, Large New York Cities and other litigating municipalities of New York State, except New York City and the Counties of Nassau and Suffolk, pursuant to a commitment to spend in each the corresponding percentages shown in Schedule C. Of this amount, at least 1.89% of the total Opioid Settlement Funds received by New York shall be set aside for Large New York Cities and at least 0.34% of the total Opioid Settlement Funds received by New York shall be

set aside for the other litigating municipalities, as listed in Schedule C. Each New York Subdivision other than New York City and the Counties of Nassau and Suffolk may apply for and receive funds from the Opioid Settlement Fund, provided however, that each such Subdivision shall, as a condition to the receipt of these funds, certify at the end of each fiscal year during which it receives such funds that all funds provided to it under this provision of the Agreement were spent on projects and programs that constitute Approved Uses and provided that it complies with the reporting requirements set forth in Section IV.E.

2. Each year the Lead State Agency will set aside approximately **55%** of the Opioid Settlement Fund (20% of the total Opioid Settlement Funds) for spending by the Lead State Agency to (a) fund State projects that constitute Approved Uses, and (b) carry out the duties of the Lead State Agency and Advisory Board under this Agreement, including oversight and administration of the Opioid Settlement Fund and the Advisory Board. No more than 5% of the total Opioid Settlement Fund may be used in any fiscal year for oversight and administrative costs of the Opioid Settlement Fund and the Advisory Board.

B. **Approved Uses.** The Approved Uses are set forth in Schedule D below. The Advisory Board may recommend to the Legislature adding or removing Approved Uses in response to changing substance use disorder needs in the state. The Advisory Board may not recommend that Approved Uses be removed from the list of Approved Uses without the vote of three-fourths of the present members of the Advisory Board.

C. **Oversight and Auditing.** The Lead State Agency will engage in oversight and audits of projects and programs funded through the Opioid Settlement Fund.

D. **New York Subdivision Reporting.** Each New York Subdivision that receives funds from the Opioid Settlement Fund under this Agreement will annually provide to the Lead State Agency and Advisory Board a detailed accounting of the spending of such funds as well as analysis and evaluation of the projects and programs it has funded. Such accounting shall be provided by August 1 of each year following the year in which such funds were spent. The Lead Agency may withhold future funds from any New York Subdivision that is delinquent in providing this reporting, until the required report is submitted.

E. **Lead Agency Reporting.** The Lead State Agency and other relevant government commissioners, in consultation with the Advisory Board, will annually provide the Governor, Speaker of the Assembly, the Temporary President of the Senate, and other legislative leaders as provided by law, a written report, which, among other things, provides a detailed accounting of the previous year's spending of all monies in the Opioid Settlement Fund, any spending by the Direct Share Subdivisions pursuant to Section II.B.5, any spending by the Large New York Cities pursuant to Section II.6, and any spending by New York City pursuant to Section II.B.7, as well as an analysis and evaluation of the projects and programs so funded. This report shall be provided on or before November 1 of each year, beginning one year after the initial deposit of monies in the Opioid Settlement Fund. At the same time, in consultation with the Advisory Board, the Lead State Agency will report annually the results of research funded by funds from this Agreement, the status of any outstanding audits, and the non-binding recommendations of the Advisory Board.

V. THE ROLE OF THE ADVISORY BOARD

The Advisory Board established pursuant N.Y. Mental Hyg. Law § 25.18(c) and Section V of Exhibit N of the New York Distributor Statewide Opioid Settlement Agreement will constitute the Advisory Board for this agreement.

VI. RETENTION OF JURISDICTION

The Supreme Court, County of Nassau, shall retain jurisdiction of the Parties for the purpose of this Agreement, including its interpretation and enforcement.

LETITIA JAMES

Attorney General of the State of New York

By: 

Date: 11/03/22

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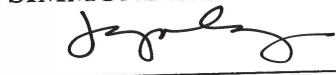
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Date: _____

ADDITIONAL SIGNATORIES:

Date: _____

Counsel for _____

Date: _____

Counsel for _____

Date: _____

Counsel for _____

Date: _____

Counsel for _____

Date: _____

Counsel for _____

Date: _____

Counsel for _____

Date: _____

Counsel for _____

Date: _____

Counsel for _____

Schedule A

Allegany	0.492651319%
Cattaraugus	0.885804166%
Chautauqua	1.712744591%
Erie	13.981832649%
Niagara	3.416877066%
Western Region	20.489909791%

Genesee	0.710630089%
Livingston	0.678797077%
Monroe	9.384433024%
Ontario	1.309944722%
Orleans	0.412856571%
Seneca	0.386847050%
Wayne	0.994089249%
Wyoming	0.411657124%
Yates	0.247909288%
Finger Lakes Region	14.537164194%

Broome	2.790673871%
Chemung	1.231939720%
Chenango	0.516475286%
Delaware	0.549364256%
Schuyler	0.208248729%
Steuben	1.137138754%
Tioga	0.542347836%
Tompkins	1.177586745%
Southern Tier Region	8.153775199%

Cayuga	0.903523653%
Cortland	0.541036257%
Madison	0.810595101%
Onondaga	6.323758786%
Oswego	1.549495093%
Central NY Region	10.128408890%

Fulton	0.462070473%
Herkimer	0.658308079%
Montgomery	0.453395949%
Oneida	2.826733181%

Otsego	0.670962131%
Schoharie	0.277769778%
Mohawk Valley Region	5.349239592%

Clinton	0.831513299%
Essex	0.367293246%
Franklin	0.457353060%
Hamilton	0.030269643%
Jefferson	1.273686826%
Lewis	0.251124198%
St. Lawrence	1.234262202%
North Country Region	4.445502475%

Albany	2.791375201%
Columbia	0.656790382%
Greene	0.793267678%
Rensselaer	1.270734936%
Saratoga	1.679317072%
Schenectady	1.217397796%
Warren	0.612162823%
Washington	0.479903545%
Capital Region	9.500949434%

Dutchess	4.381104459%
Orange	5.187725669%
Putnam	1.184886753%
Rockland	3.081816868%
Sullivan	1.888626559%
Ulster	2.462996041%
Westchester	9.207894077%
Mid-Hudson Region	27.395050426%

Schedule B

<u>Albany</u>	<u>6.69566439%</u>
<u>Buffalo</u>	<u>33.53818545%</u>
<u>Rochester</u>	<u>22.51041501%</u>
<u>Syracuse</u>	<u>15.16878370%</u>
<u>Yonkers</u>	<u>22.08695145%</u>

Schedule C

<u>Western Region</u>	<u>17.702081918%</u>
<u>Finger Lakes Region</u>	<u>12.559258389%</u>
<u>Southern Tier Region</u>	<u>7.044384186%</u>
<u>Central NY Region</u>	<u>8.750352037%</u>
<u>Mohawk Valley Region</u>	<u>4.621429690%</u>
<u>North Country Region</u>	<u>3.840653755%</u>
<u>Capital Region</u>	<u>8.208263818%</u>
<u>Mid-Hudson Region</u>	<u>23.667718977%</u>
<u>Albany</u>	<u>0.772105290%</u>
<u>Buffalo</u>	<u>3.867429560%</u>
<u>Rochester</u>	<u>2.595770859%</u>
<u>Syracuse</u>	<u>1.749176400%</u>
<u>Yonkers</u>	<u>2.546939490%</u>
<u>Amherst Town</u>	<u>0.245448607%</u>
<u>Amsterdam City</u>	<u>0.044507465%</u>
<u>Auburn City</u>	<u>0.141444557%</u>
<u>Cheektowaga Town</u>	<u>0.060164531%</u>
<u>Geneva City</u>	<u>0.058136132%</u>
<u>Herkimer Village</u>	<u>0.025864082%</u>
<u>Ithaca City</u>	<u>0.119355968%</u>
<u>Lackawanna City</u>	<u>0.034046116%</u>
<u>Lancaster Town</u>	<u>0.039745967%</u>
<u>Mount Vernon City</u>	<u>0.076705358%</u>
<u>Ogdensburg City</u>	<u>0.033771645%</u>
<u>Plattsburgh City</u>	<u>0.049991967%</u>
<u>Poughkeepsie City</u>	<u>0.222941118%</u>
<u>Rome City</u>	<u>0.116809770%</u>
<u>Saratoga Springs City</u>	<u>0.105585390%</u>
<u>Schenectady City</u>	<u>0.123453584%</u>
<u>Tonawanda Town</u>	<u>0.063690259%</u>
<u>Troy City</u>	<u>0.179747858%</u>
<u>Utica City</u>	<u>0.333025258%</u>

Schedule D – Approved Uses

II. 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, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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 services that include the full American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions, including but not limited to:
 - f. Medication-Assisted Treatment (MAT);
 - g. Abstinence-based treatment;
 - h. Treatment, recovery, or other services provided by states, subdivisions, community health centers; non-for-profit providers; or for-profit providers;
 - i. Treatment by providers that focus on OUD treatment as well as treatment by providers that offer OUD treatment along with treatment for other SUD/MH conditions; or
 - j. Evidence-informed residential services programs, as noted below.
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, evidence-informed or promising practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Treatment of mental health trauma resulting from the traumatic experiences of the opioid user (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 detoxification (detox) and withdrawal management services for persons with OUD and any co-occurring SUD/MH conditions, including medical detox, referral to treatment, or connections to other services or supports.
8. Training for MAT for health care providers, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Scholarships and supports for certified addiction counselors and other mental and behavioral health providers involved in addressing OUD any co-occurring SUD/MH 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. Scholarships for persons to become certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field, and scholarships for certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field for continuing education and licensing fees.
13. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD and provide technical assistance and professional support for clinicians who have obtained a DATA 2000 waiver.
14. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.
15. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide the full continuum of care of recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, residential treatment, medical detox services, peer support services and counseling, community navigators, case management, transportation, and connections to community-based services.
2. 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.
3. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, or training for housing providers.
4. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
5. 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.

6. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
8. Identifying successful recovery programs such as physician, pilot, and college recovery programs, and providing support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
9. Engaging non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to manage the opioid user in the family.
10. Training and development of procedures for government staff to appropriately interact and provide social and other services to current and recovering opioid users, including reducing stigma.
11. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
12. Create or support culturally-appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
13. Create and/or support recovery high schools.

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

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

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders.
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 most common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
6. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into community treatment or recovery services through a bridge clinic or similar approach.

7. 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.
8. 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.
9. 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.
10. Provide funding for peer navigators, recovery coaches, care coordinators, or care managers that offer assistance to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced on opioid overdose.
11. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and supporting prevention, intervention, treatment, and recovery programs focused on young people.
12. Develop and support best practices on addressing OUD in the workplace.
13. Support assistance programs for health care providers with OUD.
14. Engage non-profits and faith community as a system to support outreach for treatment.
15. 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.
16. Create or support intake and call centers to facilitate education and access to treatment, prevention, and recovery services for persons with OUD and any co-occurring SUD/MH conditions.
17. Develop or support a National Treatment Availability Clearinghouse – a multistate/nationally accessible database whereby health care providers can list locations for currently available in-patient and out-patient OUD treatment services that are accessible on a real-time basis by persons who seek treatment.

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 – or are at risk of becoming involved – in the criminal justice system through evidence-based, evidence-informed or promising programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest and pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
 - a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);
 - b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;
 - c. “Naloxone Plus” strategies, which work to ensure that individuals who have received Naloxone to reverse the

effects of an overdose are then linked to treatment programs or other appropriate services;

- d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model; or
 - e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 - f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise and to reduce perceived barriers associated with law enforcement 911 responses.
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 for persons with OUD and any co-occurring SUD/MH conditions, but only if they provide referrals to evidence-informed treatment, including MAT.
 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, who 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, through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based, evidence-informed, or promising 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 educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Training for obstetricians and other healthcare personnel that work with pregnant women and their families regarding OUD treatment and any co-occurring SUD/MH conditions.
3. Provide training to health care providers who work with pregnant or parenting women on best practices for

compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

4. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.
5. Enhanced family supports and child care services for parents with OUD and any cooccurring SUD/MH conditions.
6. 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.
7. 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.
8. 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.

II. PREVENTION

A. 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, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
2. Academic counter-detailing to educate prescribers on appropriate opioids prescribing.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:
 - a. Increase the number of prescribers using PDMPs;
 - b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
 - c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD.
6. Development and implementation of a national PDMP – Fund development of a multistate/national PDMP that permits information sharing while providing appropriate safeguards on sharing of private health information,

including but not limited to:

- a. Integration of PDMP data with electronic health records, overdose episodes, and decision support tools for health care providers relating to OUD.
 - b. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database.
7. Increase electronic prescribing to prevent diversion or forgery.
 8. Educating Dispensers on appropriate opioid dispensing.

B. PREVENT MISUSE OF OPIOIDS

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

1. Corrective advertising or affirmative public education campaigns based on evidence.
2. Public education relating to drug disposal.
3. Drug take-back disposal or destruction programs.
4. Fund community anti-drug coalitions that engage in drug prevention efforts.
5. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).
6. Engaging non-profits and faith community as a system to support prevention.
7. Support evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
8. 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.
9. Support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
10. 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.
11. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

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

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

1. Increasing availability and distribution of naloxone and other drugs that treat overdoses to first responders, overdose patients, opioid users, families and friends of opioid users, schools, community navigators and outreach workers, drug offenders upon release from jail/prison, and other members of the general public.
2. Public health entities provide free naloxone to anyone in the community, including but not limited to provision of intra-nasal naloxone in settings where other options are not available or allowed.
3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, and other members of the general public.
4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.
7. Public education relating to immunity and Good Samaritan laws.
8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.
13. Support screening for fentanyl in routine clinical toxicology testing.

III. OTHER STRATEGIES

A. FIRST RESPONDERS

In addition to items C8, D1 through D7, H1, H3, and H8, support the following:

1. Law enforcement expenditures related to the opioid epidemic
2. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
3. Provisions of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

B. LEADERSHIP, PLANNING AND COORDINATION

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

1. Community regional planning to identify goals for reducing harms related to the opioid epidemic, to identify areas and populations with the greatest needs for treatment intervention services, or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list including, but not limited to costs associated with local opioid task forces, community buprenorphine waiver trainings, and coordination and operation of community-based treatment prevention programming.
2. A government dashboard to track key opioid-related indicators and supports as identified through collaborative 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.

C. TRAINING

In addition to the training referred to in items above A7, A8, A9, A12, A13, A14, A15, B7, B10, C3, C5, E2, E4, F1, F3, F8, G5, H3, H12, and I2, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or network programs and services regarding the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-systems 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.).

D. RESEARCH

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

1. Monitoring, surveillance, and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.
3. Research 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. Research on expanded modalities such as prescription methadone that can expand access to MAT.
8. 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.
9. 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.
10. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

E. POST-MORTEM

1. Toxicology tests for the range of synthetic opioids presently seen in overdose deaths as well as newly evolving synthetic opioids infiltrating the drug supply.
2. Toxicology method development and method validation for the range of synthetic opioids observed now and in the future, including the cost of installation, maintenance, repairs and training of capital equipment.
3. Autopsies in cases of overdose deaths resulting from opioids and synthetic opioids.
4. Additional storage space/facilities for bodies directly related to opioid or synthetic opioid related deaths.
5. Comprehensive death investigations for individuals where a death is caused by or suspected to have been caused by an opioid or synthetic opioid overdose, whether intentional or accidental.

6. Indigent burial for unclaimed remains resulting from overdose deaths.
7. Navigation-to-care services for individuals with opioid use disorder who are encountered by the medical examiner's office as either family and/or social network members of decedents dying of opioid overdose.
8. Epidemiologic data management and reporting to public health and public safety stakeholders regarding opioid overdose fatalities.