IN THE UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

In re:	)	Chapter 11
MALLINCKRODT PLC, *et al.,*[1]	)	Case No. 20-12522 (JTD)
Debtors.	)	(Jointly Administered)

NOTICE OF FILING:
STATEWIDE ABATEMENT AGREEMENT FILED ON BEHALF OF NEW YORK

PLEASE TAKE NOTICE that, pursuant to Section 5 of the National Opioid Abatement Trust II Distribution Procedures, the NOAT II Trustees file the attached Exhibit.

Dated: August 16, 2022
Wilmington, Delaware

Respectfully submitted,

CAMPBELL & LEVINE, LLC

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General Counsel to the National Opioid Abatement Trust II

[1] A complete list of the Debtors in these Chapter 11 Cases may be obtained on the website of the Debtors' claims and noticing agent at http://restructuring.primeclerk.com/Mallinckrodt. The Debtors' mailing address is 675 McDonnell Blvd., Hazelwood, Missouri 63042.

EXHIBIT

NEW YORK OPIOID SETTLEMENT SHARING AGREEMENT (MALLINCKRODT)

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 the Amended Joint Chapter 11 Plan of Reorganization of Mallinckrodt PLC., and Its Debtor Affiliates ("Mallinckrodt Bankruptcy Plan") and constitutes a "Statewide Abatement Agreement" as defined in the Mallinckrodt Bankruptcy Plan and a "Statewide Opioid 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 Mallinckrodt PLC., as well as individuals and companies released as part of *In re: Mallinckrodt PLC, et al.,* Case No. 20-12522-jtd (Bankr. D. Del.) ("Mallinckrodt");

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

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 Mallinckrodt throughout the State of New York;

Whereas, all non-federal public claimants agreed that all value received would be dedicated towards abatement, and

Now therefore, the State of New York and the New York Subdivisions enter into this Agreement relating to the allocation, distribution, and use of the New York NOAT II Funds received as a result of the Mallinckrodt Bankruptcy Plan.

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 C.

B. "Lead State Agency" means the New York State Office of Addiction Services and Supports. As provided below, 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 Mallinckrodt Bankruptcy Plan deposited into the New York Opioid Settlement Fund.

C. The "Advisory Board" means the advisory board created and described by N.Y. Mental Hyg. Law § 25.18(c).

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. "New York Subdivisions" means each county, city, town, village or special district in New York.

F. "NOAT II Funds" means the funds distributed to non-federal governmental entities from the National Opioid Abatement Trust II, including to New York, pursuant to the Mallinckrodt Bankruptcy Plan.

G. "Mallinckrodt Opioid Settlement Funds" shall mean the monetary amounts obtained by the State of New York as NOAT II Funds received from the Mallinckrodt Bankruptcy Plan.

H. "Parties" means the State of New York and the New York Subdivisions who execute this agreement.

I. "New York Opioid Settlement Fund" means the fund established pursuant to N. Y. Finance Law § 99-NN.

II. GENERAL FINANCIAL AND STRUCTURE TERMS

A. **Scope of Agreement.** This Agreement applies to the New York NOAT II funds received as a result of the Mallinckrodt Bankruptcy Plan.

B. **Allocation and Distribution of Funds for Restitution and Abatement**. Mallinckrodt Opioid Settlement Funds shall be allocated and distributed as follows:

1. **16.39%** to the Lead State Agency to be placed in the New York Opioid Settlement Fund for Regional Spending on Approved Uses. In combination, the amount of Regional Spending of the New York Opioid Settlement Fund committed to cities other than New York City with a 2020 population of more than 90,000 shall not be less than 1.89% of the total Mallinckrodt Opioid Settlement Funds.

2. **37.5%** to the Lead State Agency to be placed in the New York Opioid Settlement Fund for Discretionary Spending on Approved Uses and for Administration of the New York Opioid Settlement Fund.

3. **10.8%** to the Direct Share Subdivisions for spending on Approved Uses pursuant to Schedule A ("Direct Share Funds").

4. **6.68%** to the County of Nassau for spending on Approved Uses.

5. **8.63%** to the County of Suffolk for spending on Approved Uses.

6. **20%** 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.

D. **Direct Payment of Certain Funds**. All Mallinckrodt Opioid Settlement Funds allocated to the Direct Share Subdivisions, the Counties of Nassau and Suffolk, and the City of New York pursuant to Sections II.B.3, 4, 5, and 6 shall be paid directly by the National Opioid Abatement Trust II.

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

Distribution of the Direct Share Subdivision Funds. The Direct Share Funds shall be paid to the Direct Share Subdivisions pursuant to Section II.B.3 in the allocation set forth in Schedule A to this Agreement.

A. Certification of Spending on Approved Uses. Each year, the Direct Share Subdivisions, the City of New York and the Counties of Nassau and Suffolk shall in a manner determined by the National Opioid Abatement Trust II certify and report that all funds distributed to them pursuant to Sections II.B.3, 4, 5 and 6 of this Agreement, were spent consistent with the requirements established by the National Opioid Abatement Trust II. 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 MALLINCKRODT OPIOID SETTLEMENT FUNDS

A. Funding the New York Opioid Settlement Fund.

1. Each year the Lead State Agency will allocate approximately **30.4**% of the Mallinckrodt Opioid Settlement Funds (16.39% of the total Mallinckrodt Opioid Settlement Funds) for Approved Uses in the various regions and large cities of New York State, except New York City and the Counties of Nassau and Suffolk, pursuant to a commitment to spend in each such region and each city other than New York City with a population of more than 90,000 the corresponding percentages shown in Schedule B. Of this amount, at least 1.89% of the total Opioid Settlement Funds received by New York shall be set aside for cities other than New York City with a population of more than 90,000. Each New York Subdivision other than New York City and the Counties of Nassau and Suffolk may apply for and receive Mallinckrodt Opioid Settlement Funds, 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 **69.6**% of the Mallinckrodt Opioid Settlement Funds (37.5% of the total Mallinckrodt 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 Mallinckrodt Opioid Settlement Funds and the Advisory Board. No more than 5% of the total Mallinckrodt Opioid Settlement Funds may be used in any fiscal year for oversight and administrative costs of the New York Opioid Settlement Fund and the Advisory Board.

B. **Approved Uses.** The Approved Uses are set forth in Schedule C 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 New York Opioid Settlement Fund.

D. New York Subdivision Reporting. Each New York Subdivision that receives funds from the New York Opioid Settlement Fund under this Agreement will annually provide to the Lead State Agency and Advisory Board, and post on its website, a detailed accounting of the receipt and spending of such funds consistent with Section 7 of the NOAT II Distribution Procedures of the Mallinckrodt Bankruptcy Plan. 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 post on its website and 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 receipt and spending of all monies in the New York Opioid Settlement Fund from the Mallinckrodt Bankruptcy Plan) consistent with Section 7 of the NOAT II Distribution Procedures of the Mallinckrodt Bankruptcy Plan. This report shall be provided on or before November 1 of each year, beginning one year after the initial deposit of Mallinckrodt Opioid Settlement Funds into the New York 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 ADVISORY BOARD

The Advisory Board established pursuant N.Y. Mental Hyg. Law § 25.18(c) will constitute as the Advisory Board for this agreement.

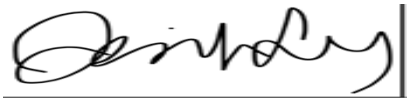
VI. RETENTION OF JURISDICTION

The Bankruptcy Court in which the Mallinckrodt Bankruptcy Plan is entered shall retain jurisdiction over the National Opioid Abatement Trust II. In the event of any matter arising under the National Opioid Abatement Trust II Distribution Procedures involving the State of New York and its political subdivisions the principal Coordinating Judge assigned by the State of New York Opioids Litigation Coordination Panel shall have jurisdiction.

VII. CONFLICTS

In the event of any conflict between the Mallinckrodt Bankruptcy Plan and this Agreement, the Mallinckrodt Bankruptcy Plan shall control.

LETITIA JAMES
Attorney General of the State of New York

By:  Date: 8/15/22

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Cortland County
Essex County
Franklin County
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Kingston, City of
Lancaster, Town of
Livingston County
Madison County
Mount Vernon
Nassau County
Niagara County
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Orleans County
Otsego County
Poughkeepsie, City of
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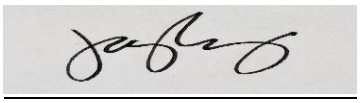

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Ontario County
Orange County
Oswego County
Schenectady County
Seneca County
St. Lawrence County
Suffolk County
Sullivan County
Ulster County
Washington County
Wyoming County

ADDITIONAL SIGNATORIES:

_____
_____ Date:_____
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Counsel for _____

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_____ Date:_____
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Counsel for _____

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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

Western Region	**18.127131908%**
Finger Lakes Region	**12.860822502%**
Southern Tier Region	**7.213529004%**
Central NY Region	**8.960459360%**
Mohawk Valley Region	**4.732396222%**
North Country Region	**3.932872842%**
Capital Region	**8.405354899%**
Mid-Hudson Region	**24.236011664%**
Albany	**0.772105290%**
Buffalo	**3.867429560%**
Rochester	**2.595770859%**
Syracuse	**1.749176400%**
Yonkers	**2.546939490%**

Schedule C – Approved Uses

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, the following[1]:

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. 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.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach

[1] As used in this Schedule C, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the National Opioid Abatement Trust Distribution Procedures.

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 behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD 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. 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.

14. 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 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 following:

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. 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 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, 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, 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. 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, the following:

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 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, the following:

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. Training for obstetricians or other healthcare personnel that 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; 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 Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

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

7. Enhanced family supports 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. 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. Fund 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. 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:

    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. Increase electronic prescribing to prevent diversion or forgery.

8. Educate 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. Fund 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. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. 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).

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

8. Fund 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 of 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. Increase 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. 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.

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. Educate 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, the following:

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.