Opioid Litigation – Probably the most complicated civil litigation ever!

I. Background

The story of the opioid epidemic begins with a history of the Sackler family, and their development and marketing of the drug called Oxycontin. According to the Sacklers, the purpose of the drug was to alleviate pain – a major unsolved problem. However, according to several written accounts,[1] what the Sacklers did to promote the drug was tragic. To increase sales, they misrepresented the truth as to its addictive nature and heavily courted physicians to prescribe (indeed oversubscribe!) the drug to their patients. Strategic advertising and other aggressive marketing tools were used to enhance sales. A billion dollar business was created through a corporate structure now known as Purdue Pharma, formerly the Purdue Frederick Company. The Oxycontin opioid epidemic has now morphed into today's use of fentanyl with daily drug overdose and death on our nation's streets. But, as the story has unfolded, it is not only Purdue Pharma, but other manufacturers, distributors and retailers who share the blame.

II. Litigation Highlights

Opioid litigation is complicated not only because of the multiple plaintiffs and defendants involved, but the large number of lawsuits filed in both State and Federal courts across the Country. Some verdicts and settlements have been reached, while others are pending. Set forth below are some of the highlights.

A. Plaintiffs

(1) Local Government and Indian Tribes.

[1] Dopesick: Dealers, Doctors and the Drug Company that Addicted America by Beth Macy
Pain Killer: An Empire of Deceit and the Origin of America's Opioid Epidemic by Barry Meier
Empire Of Pain: The Secret History of the Sackler Dynasty by Patrick Raddon Keefe
Pharma: Greed, Lies and the Poisoning of America by Gerald Posner
Fentanyl, Inc.: How Rogue Chemists Are Creating the Deadliest Wave of the Opioid Epidemic by Ben Westhoff

The vast majority of cases are the over more than 3,000 lawsuits filed by cities, counties and Indian Tribes consolidated in multidistrict litigation (MDL) known as the National Prescription Opiate Litigation now pending in the United States District Court for the Northern District of Ohio. (Master Docket Number 1:17-md-2804) The case is pending before Judge Dan Polster, who has taken an active role in the case in several different ways, including the following:

(a) he has made it clear that any settlement monies or jury-awarded compensation must be used for opioid abatement purposes, unlike the earlier 1998 tobacco nationwide settlement entered into by the tobacco companies and the State Attorney Generals where the monies could be used for unrelated and non-health purposes.

(b) he has taken an active role in the assignment of 'bellwether' cases, which are individual cases which serve as examples of how all the 3000 other cases might turn out.

Some local governments have sued separately in state courts, with mixed results. For example, the Santa Clara County Counsel's office, along with the Orange County District Attorney's office, filed the nation's first, government-initiated lawsuit against the manufacturers. The City of Oakland and Los Angeles County later joined the lawsuit. One of their claims was a public nuisance claim which the Orange County Judge dismissed. The matter is on appeal. *See People of the State of California v. Purdue Pharma, et al.,* Orange County Superior Court, Case No. CGC-13-534198. As set forth below, other cases have reached a different result, while other cases are pending.

(2) States

State Attorney Generals have followed their own paths, but, as discussed below, the majority (46) have joined with their local entities in a settlement with

Johnson & Johnson (through its US-based division, Janssen Pharmaceuticals) and the three major distributors.

Some states have filed their own actions, sometimes with different results. For example, in November 2021, the Oklahoma Supreme Court overturned a $465 million judgment against Johnson & Johnson on the ground that the State's public nuisance law did not apply to the manufacturing, and sales of prescription opioids. A case in New York reached a different result. In March 2019, the State of New York and two counties, both on Long Island, had filed a landmark case, which was the first of its kind, targeting all points of the prescription Opioid supply chain from manufacturers to pharmacy chains that filled prescriptions. Although most of the defendants settled the case along the way, on December 30, 2021, a jury found manufacturer Teva Pharmaceuticals and distributor Anda liable on the second opioid-related lawsuit to reach a jury verdict. As discussed below, the first opioid-related lawsuit to reach a jury verdict was in Ohio.

B. Defendants

(1) Opioid Manufacturers: Purdue, Johnson & Johnson, Etc.

Purdue Pharma has been the main opioid manufacturer to be sued. It is currently involved in a unique bankruptcy proceeding with the underlying idea that it would come out as a new corporation, the Sacklers would leave, the patent for Oxycontin (and its antidote Naloxone) would remain with the new company with profits to be used to fight the opioid epidemic. Settlement figures are now up to $6 billion, but the matter is still not final.

Mallinckrodt is also in bankruptcy reorganization with a $1.7 billion to go to opioid abatement recently approved.

Johnson & Johnson – see below with regard to distributors' settlement.

Allergan Finance LLC, Teva Pharmaceuticals, Endo International continue to be involved in litigation.

(2) Distributors – McKesson, Amerisource Bergen, Cardinal Health

In the last week of February, it was announced that the nation's largest distributors (see above) and the manufacturer Johnson & Johnson (through its US-based Janssen Pharmaceuticals) and a super majority of states (46) and local governments had agreed to a settlement of $26 billion. Johnson & Johnson will pay $5 billion over 5 years; the distributors will pay a combined $21 billion over 18 years. At least, 85 percent of the payments will be dedicated to addiction treatment and prevention services. A full description of the settlement is contained in the New York Times article entitled "26 Billion Deal To End Opioid Lawsuits Is Finalized" dated February 26, 2022 (see exhibit A).

In California, a deal was struck between a working group of city attorneys, county counsel and their outside counsel with the State Attorney General, whereby 15% of the proceeds will go to litigating entities with the remaining 15% to go to the state and 70% to go to the local entities for opioid abatement purposes. Details of the Agreement are set forth in the California State - Subdivision Agreement attached as "Exhibit B." This agreement also incorporates a description of how the funds may be used by referring to the "List of Opioid Remediation Uses," which is Exhibit E of the Distributor Settlement.[2] That exhibit is attached here as Exhibit "C"

(3) Retailers – CVS, Walgreens, and Walmart

On August 24, 2021 on a bellwether case in Ohio, a Federal jury found that three pharmacy chains (CVS, Walgreen's and Walmart) had played a key role in feeding the opioid crisis in Lake and Trumbull counties. This verdict was the first in the nation involving the dispensing of prescription pain killers. The jury concluded that the three chains had created a public nuisance in the counties on their supplying

[2] The website "nationalopioidssettlement.com" has a wealth of information about the opioid settlements. It should also be emphasized that local entities should stay in touch with their County Counsel and the League to make certain that they file any required forms and meet the requirements for any money to which they may be entitled.

of opioid pills. Other cases against the retailers are pending. (One important bellwether case is now pending before Judge Charles Breyer in San Francisco Federal district court. It is *City and County of San Francisco, et al.* v. *Purdue Pharma, et al*., Case No. 3-28-cv-07591-CRB).

(4) McKinsey

Recently McKinsey has been sued by the State of California and others because of its advice and consultation given to drug companies. *See e.g., People of the State of California v. McKinsey & Co.*, Alameda County Superior Court, Case No. RG21087649.

III. Conclusion

After many years of litigation and thousands of lawsuits, some cases have settled; others are on-going, while still others appear to be starting to wind down. But the severity of the opioid epidemic remains. Few, if any, communities are without tragic examples of drug overdose and death. And while the settlement dollars seem large in the abstract, the truth is that the amount of money resulting from the litigation will never be enough to solve this epidemic.

That is why it is critical that all local governments (and the States and Federal government) focus on best practices and work in a coordinated and creative fashion to end this tragic epidemic.

EXHIBIT A

The New York Times https://www.nytimes.com/2022/02/25/health/opioids-settlement-distributors-johnson.html

Companies Finalize $26 Billion Deal With States and Cities to End Opioid Lawsuits

The first checks could be cut in April. The money — from the nation's three major pharmaceutical distributors and Johnson & Johnson — will be used for addiction treatment and prevention.

By Jan Hoffman
Feb. 25, 2022

The nation's three largest drug distributors and a major pharmaceutical manufacturer announced Friday that a supermajority of states and localities had accepted the terms of their $26 billion offer to settle thousands of civil claims related to the deadly opioid crisis. The first checks are expected to go out in early April.

Through its pharmaceutical division, Janssen, Johnson & Johnson will pay $5 billion, broken into annual payments over nine years. McKesson, Cardinal Health and AmerisourceBergen, the distributors, will pay a combined $21 billion over 18 years. At least 85 percent of the payments will be dedicated to addiction treatment and prevention services.

By signing onto the deal, thousands of local governments as well as states have agreed to drop their opioid lawsuits against the companies and also pledge not to bring any future action.

In its sweep and bottom line, the deal is second only to the Big Tobacco settlement of the late 1990s as a multistate agreement.

The total amount includes almost $2 billion that will cover fees and costs for the platoons of lawyers nationwide who represented local governments as well as some states and built much of the legal strategy in the cases. Those payments will go out over roughly seven years.

There are no separate funds to compensate families and individual victims of the opioid crisis.

The announcement is a milestone in the nationwide opioid litigation, which began in 2014 with a few cities and counties filing lawsuits against five drug manufacturers. But as thousands of governmental plaintiffs eventually filed claims, the cases reached across the pharmaceutical industry, to distributors and retailers as well. The actions gelled into a modern legal behemoth that is still far from fully resolved, featuring, most prominently, the cases against Purdue Pharma.

The crisis continues to take a terrible toll: More than 500,000 Americans have died from overdoses to prescription and illegal street opioids since 1999, according to federal data.

The distributors and Johnson & Johnson released statements Friday morning, noting that the deal is not an admission of wrongdoing and that they strongly dispute the allegations. The distributors said in a joint statement that they believed that "the implementation of this settlement is a key milestone toward achieving broad resolution of governmental opioid claims and delivering meaningful relief to communities across the United States that have been impacted by the epidemic."

Johnson & Johnson also added that it would "continue to defend itself against any litigation that this final settlement agreement does not resolve," noting that it no longer sells prescription opioid medication in the United States.

When Johnson & Johnson, the distributors and a smaller group of states announced their proposed settlement in July, the companies said they required an unspecified majority of plaintiffs to sign on, to guarantee an end to litigation. The announcement Friday morning signals that a sufficient threshold has been reached, or at least 90 percent of those governments eligible to participate, and 46 of 49 eligible states for the distributors and 45 for Johnson & Johnson. Courts in each state will now have to sign off on the agreements, a process that is expected to go relatively smoothly and swiftly.

According to the agreements, a state will get its full allocation if all its local governments sign on to the deal. For example, all 100 North Carolina counties and 47 municipalities have agreed, and the state will get its allotment of $750 million.

"North Carolina communities will begin to receive money this year to help people struggling with substance abuse," said Josh Stein, the state's attorney general and a leader of a bipartisan coalition of states that negotiated with the companies and local governments for nearly three years. "The treatment, recovery, prevention and harm reduction services that will be available across the state will help people regain control over their lives and make North Carolina safer."

A few holdout states and localities still remain against either the distributors or Johnson & Johnson, including Washington, Oklahoma and Alabama. But legal experts say that stance could be perilous: The outcomes from a few completed trials point to favorable resolutions for the companies, suggesting that continuing to do battle with those governments who declined the deal is a risk the companies are willing to take.

This month, the same companies announced a tentative settlement with Native American tribes that have suffered disproportionately high addiction and death rates during the opioid epidemic. In combination with a $75 million deal that distributors struck with the Cherokee Nation last fall, the 574 federally recognized tribes could receive $665 million in payouts over nine years. An overwhelming majority of tribes are expected to sign on to the proposal.

A major theme coursing throughout the opioid litigation has been the aggressive marketing of the drugs, which went all but unchecked for years. Distributors almost never sent up warning flares when pharmacy clients took deliveries of quantities of opioids that were wildly disproportionate to the local population. A central feature of the new deal is that the distributors must set up an independent clearinghouse to track and report one another's shipments, a mechanism intended to raise red flags immediately when outsize orders are made.

During the settlement negotiations, a secondary series of talks between the states and the local governments over the allocation of the funds was also unfolding. By now, about two dozen states have worked up their own distribution plans with local cities and counties that also sued the companies.

The executive committee of lawyers, including Joe Rice, Elizabeth Cabraser and Jayne Conroy, who negotiated for local governments, released a statement saying, "We arrived at this moment after years of work by community leaders across the country who committed themselves to seeking funds they need to combat the opioid epidemic."

They continued, "While this is a vital step, it is only one of the many that are necessary to put an end to this crisis."

EXHIBIT B

Proposed California State-Subdivision Agreement
Regarding Distribution and Use of
Settlement Funds – Distributor Settlement

1. Introduction

Pursuant to the Distributor Settlement Agreement, dated as of July 21, 2021, and any revision thereto (the "Distributor Settlement Agreement"), including Section V and Exhibit O, the State of California proposes this agreement (the "CA Distributor Allocation Agreement") to govern the allocation, distribution, and use of Settlement Fund payments made to California pursuant to Sections IV and V of the Distributor Settlement Agreement.[1] For the avoidance of doubt, this agreement does not apply to payments made pursuant to Sections IX or X of the Distributor Settlement Agreement.

Pursuant to Exhibit O, Paragraph 4, of the Distributor Settlement Agreement, acceptance of this CA Distributor Allocation Agreement is a requirement to be an Initial Participating Subdivision.

2. Definitions

a) *CA Participating Subdivision* means a Participating Subdivision that is also (a) a Plaintiff Subdivision and/or (b) a Primary Subdivision with a population equal to or greater than 10,000. For the avoidance of doubt, eligible CA Participating Subdivisions are those California subdivisions listed in Exhibit C (excluding Litigating Special Districts) and/or Exhibit I to the Distributor Settlement Agreement.

b) *Janssen Settlement Agreement* means the Janssen Settlement Agreement dated July 30, 2021, and any revision thereto.

c) *Litigating Special District* means a school district, fire protection district, health authority, health plan, or other special district that has filed a lawsuit against an Opioid Defendant. Litigating Special Districts include Downey Unified School District, Elk Grove Unified School District, Kern High School District, Montezuma Fire Protection District (located in Stockton, California), Santa Barbara San Luis Obispo Regional Health Authority, Inland Empire Health Plan, Health Plan of San Joaquin, and LA Care Health Plan.

d) *Plaintiff Subdivision* means a Subdivision located in California, other than a Litigating Special District, that filed a lawsuit, on behalf of the Subdivision and/or through an official of the Subdivision on behalf of the People of the State of California, against one or more Opioid Defendants prior to October 1, 2020.

[1] A parallel but separate agreement (the "CA Janssen Allocation Agreement") will govern the allocation, distribution, and use of settlement fund payments under the Janssen Settlement Agreement. An eligible Subdivision may elect to participate in either the Distributor Settlement or the Janssen Settlement, or in both.

e) *Opioid Defendant* means any defendant (including but not limited to Johnson & Johnson, Janssen Pharmaceuticals, Inc., Purdue Pharma L.P., Cardinal Health, Inc., AmerisourceBergen Corporation, and McKesson Corporation) named in a lawsuit seeking damages, abatement, or other remedies related to or caused by the opioid public health crisis in any lawsuit brought by any state or local government on or before October 1, 2020.

3. General Terms

This agreement is subject to the requirements of the Distributor Settlement Agreement, as well as applicable law, and the Distributor Settlement Agreement governs over any inconsistent provision of this CA Distributor Allocation Agreement. Terms used in this CA Distributor Allocation Agreement have the same meaning as in the Distributor Settlement Agreement unless otherwise defined herein.

Pursuant to Section V(D)(1) of the Distributor Settlement Agreement, (a) all Settlement Fund payments will be used for Opioid Remediation, except as allowed by Section V(B)(2) of the Distributor Settlement Agreement; and (b) at least seventy percent (70%) of Settlement Fund payment amounts will be used solely for future Opioid Remediation.

4. State Allocation

The Settlement Fund payments to California,[2] pursuant to the Distributor Settlement Agreement, shall be allocated as follows: 15% to the State Fund; 70% to the Abatement Accounts Fund; and 15% to the Subdivision Fund. For the avoidance of doubt, all funds allocated to California from the Settlement Fund shall be combined pursuant to this CA Distributor Allocation Agreement, and 15% of that total shall be allocated to the State of California (the "State of California Allocation"), 70% to the California Abatement Accounts Fund ("CA Abatement Accounts Fund"), and 15% to the California Subdivision Fund ("CA Subdivision Fund").

A. State of California Allocation

Fifteen percent of the total Settlement Fund payments will be allocated to the State and used by the State for future Opioid Remediation.

B. CA Abatement Accounts Fund

i. Allocation of CA Abatement Accounts Funds

a) Seventy percent of the total Settlement Fund payments will be allocated to the CA Abatement Accounts Fund. The funds in the CA Abatement Accounts Fund will be

[2] For purposes of clarity, use of the term "California" refers to the geographic territory of California and the state and its local governments therein. The term "State" or "State of California" refers to the State of California as a governmental unit.

allocated based on the allocation model developed in connection with the proposed negotiating class in the National Prescription Opiate Litigation (MDL No. 2804), as adjusted to reflect only those cities and counties that are eligible, based on population or litigation status, to become a CA Participating Subdivision. The allocation percentage for such subdivisions is set forth in Appendix 1 (the "Local Allocation") to this CA Distributor Allocation Agreement. For the avoidance of doubt, Litigating Special Districts and California towns, cities, and counties with a population less than 10,000 are not eligible to receive an allocation of CA Abatement Accounts Funds.

b) A CA Participating Subdivision that is a county, or a city and county, will be allocated its Local Allocation share as of the date on which it becomes a Participating Subdivision, and will receive payments as provided in the Distributor Settlement Agreement.

c) A CA Participating Subdivision that is a city will be allocated its Local Allocation share as of the date on which it becomes a Participating Subdivision. The Local Allocation share for a city that is a CA Participating Subdivision will be paid to the county in which the city is located, rather than to the city, so long as: (a) the county is a CA Participating Subdivision, and (b) the city has not advised the Settlement Fund Administrator that it requests direct payment at least 60 days prior to a Payment Date. A Local Allocation share allocated to a city but paid to a county is not required to be spent exclusively for abatement activities in that city, but will become part of the county's share of the CA Abatement Accounts Funds, which will be used in accordance with Section 4.B.ii (Use of CA Abatement Accounts Funds) and reported on in accordance with Section 4.B.iii (CA Abatement Accounts Fund Oversight).

d) A city within a county that is a CA Participating Subdivision may opt in or out of direct payment at any time, and it may also elect direct payment of only a portion of its share, with the remainder going to the county, by providing notice to the Settlement Fund Administrator at least 60 days prior to a Payment Date. For purposes of this CA Distributor Allocation Agreement, the Cities of Los Angeles, Oakland, San Diego, San Jose and Eureka will be deemed to have elected direct payment if they become Participating Subdivisions.

e) The State will receive the Local Allocation share of any payment to the Settlement Fund that is attributable to a county or city that is eligible to become a CA Participating Subdivision, but that has not, as of the date of that payment to the Settlement Fund, become a Participating Subdivision.

f) Funds received by a CA Participating Subdivision, and not expended or encumbered within five years of receipt and in accordance with the Distributor Settlement Agreement and this CA Distributor Allocation Agreement shall be transferred to the State; provided however, that CA Participating Subdivisions have seven years to expend or encumber CA Abatement Accounts Funds designated to support capital outlay projects before they must be transferred to the State. This provision shall not apply to the Cost Reimbursement Funds, which shall be controlled by Appendix 2.

ii. Use of CA Abatement Accounts Funds

a) The CA Abatement Accounts Funds will be used for future Opioid Remediation in one or more of the areas described in the List of Opioid Remediation Uses, which is Exhibit E to the Distributor Settlement Agreement.

b) In addition to this requirement, no less than 50% of the funds received by a CA Participating Subdivision from the Abatement Accounts Fund in each calendar year will be used for one or more of the following High Impact Abatement Activities:

(1) the provision of matching funds or operating costs for substance use disorder facilities within the Behavioral Health Continuum Infrastructure Program;

(2) creating new or expanded Substance Use Disorder ("SUD") treatment infrastructure;

(3) addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD;

(4) diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction; and/or

(5) interventions to prevent drug addiction in vulnerable youth.

c) The California Department of Health Care Services ("DHCS") may add to this list (but not delete from it) by designating additional High Impact Abatement Activities. DHCS will make reasonable efforts to consult with stakeholders, including the CA Participating Subdivisions, before adding additional High Impact Abatement Activities to this list.

d) For the avoidance of doubt, and subject to the requirements of the Distributor Settlement Agreement and applicable law, CA Participating Subdivisions may form agreements or ventures, or otherwise work in collaboration with, federal, state, local, tribal or private sector entities in pursuing Opioid Remediation activities funded from the CA Abatement Accounts Fund. Further, provided that all CA Abatement Accounts Funds are used for Opioid Remediation consistent with the Distributor Settlement Agreement and this CA Distributor Allocation Agreement, a county and any cities or towns within the county may agree to reallocate their respective shares of the CA Abatement Accounts Funds among themselves, provided that any direct distribution may only be to a CA Participating Subdivision and any CA Participating Subdivision must agree to their share being reallocated.

iii. CA Abatement Accounts Fund Oversight

a) Pursuant to Section 5 below, CA Participating Subdivisions receiving settlement funds must prepare and file reports annually regarding the use of those funds. DHCS may regularly review the reports prepared by CA Participating Subdivisions about the use of CA Abatement Accounts Funds for compliance with the Distributor Settlement Agreement and this CA Distributor Allocation Agreement.

b) If DHCS determines that a CA Participating Subdivision's use of CA Abatement Accounts Funds is inconsistent with the Distributor Settlement Agreement or this CA Distributor Allocation Agreement, whether through review of reports or information from any other sources, DHCS shall send a request to meet and confer with the CA Participating Subdivision. The parties shall meet and confer in an effort to resolve the concern.

c) If the parties are unable to reach a resolution, DHCS may conduct an audit of the Subdivision's use of the CA Abatement Accounts Funds within one year of the request to meet and confer, unless the parties mutually agree in writing to extend the meet and confer time frame.

d) If the concern still cannot be resolved, the State may bring a motion or action in the court where the State has filed its Consent Judgment to resolve the concern or otherwise enforce the requirements of the Distributor Settlement Agreement or this CA Distributor Allocation Agreement. However, in no case shall any audit be conducted, or motion be brought, as to a specific expenditure of funds, more than five years after the date on which the expenditure of the funds was reported to DHCS, in accordance with this agreement.

e) Notwithstanding the foregoing, this Agreement does not limit the statutory or constitutional authority of any state or local agency or official to conduct audits, investigations, or other oversight activities, or to pursue administrative, civil, or criminal enforcement actions.

C. CA Subdivision Fund

i. Fifteen percent of the total Settlement Fund payments will be allocated to the CA Subdivision Fund. All funds in the CA Subdivision Fund will be allocated among the Plaintiff Subdivisions that are Initial Participating Subdivisions. The funds will be used, subject to any limits imposed by the Distributor Settlement Agreement and this CA Distributor Allocation Agreement, to fund future Opioid Remediation and reimburse past opioid-related expenses, which may include fees and expenses related to litigation, and to pay the reasonable fees and expenses of the Special Master as set forth in Appendix 2.

The CA Subdivision Funds will be allocated as follows:

a) First, funds in the CA Subdivision Fund shall be used to pay the Special Master's reasonable fees and expenses in accordance with the procedures and limitations set forth in Appendix 2 to this document;

b) Second, funds will be allocated to Plaintiff Subdivisions that are Initial Participating Subdivisions that have been awarded Costs, as defined by and in accordance with the procedures and limitations set forth in Appendix 2 to this document.

c) Funds remaining in the CA Subdivision Fund, which shall consist of no less than 50% of the total CA Subdivision Fund received in any year pursuant to Appendix 2, Section 2.c.v, will be distributed to Plaintiff Subdivisions that are Initial Participating Subdivisions, in relative proportion to the Local Allocation. These funds shall be used to fund future opioid-related projects and to reimburse past opioid-related expenses, which may include fees and expenses related to litigation against any Opioid Defendant.

D. Provision for State Back-Stop Agreement

On August 6, 2021, Judge Dan Polster of the U.S. District Court, Northern District of Ohio, Eastern Division, issued an order (ECF Docket Number 3814) ("MDL Fees Order") in the National Prescription Opiate Litigation (MDL No. 2804) "cap[ping] all applicable contingent fee agreements at 15%." Private counsel representing Plaintiff Subdivisions should seek its contingency fees and costs from the Attorney Fee Fund or Cost Funds under the Distributor Settlement Agreement and, if applicable, the Janssen Settlement Agreement.

A Plaintiff Subdivision may separately agree to use its share of the CA Subdivision Fund to pay for fees or costs incurred by its contingency-fee counsel ("State Back-Stop Agreement"), pursuant to Exhibit R, section I(R), of the Distributor Settlement Agreement and the MDL Fees Order, so long as such contingency fees do not exceed a total contingency fee of 15% of the total gross recovery of the Plaintiff Subdivision pursuant to the Distributor Settlement, and if applicable, the Janssen Settlement, inclusive of contingency fees from the national Attorney Fee Fund and this State Back-Stop Agreement. Before seeking fees or litigation costs and expenses from a State Back-Stop Agreement, private counsel representing Plaintiff Subdivisions must first seek contingency fees and costs from the Attorney Fee Fund or Cost Funds created under the Distributor Settlement Agreement and, if applicable, the Janssen Settlement Agreement. Further, private counsel may only seek reimbursement for litigation fees and costs that have not previously been reimbursed through prior settlements or judgments.

To effectuate a State Back-Stop Agreement pursuant to this section, an agreement in the form of Appendix 3 may be entered into by a Plaintiff Subdivision, private counsel, and the California Office of the Attorney General. The California Office of the Attorney General shall, upon the request of a Plaintiff Subdivision, execute any agreement executed by a Plaintiff Subdivision and its private counsel if it is in the form of Appendix 3. The California Office of the Attorney

General will also consider requests from Plaintiff Subdivisions to execute and enter into agreements presented in other forms.

For the avoidance of doubt, this agreement does not require a Plaintiff Subdivision to request or enter into a State Back-Stop Agreement, and no State Back-Stop Agreement shall impose any duty or obligation on the State of California or any of its agencies or officers, including without limitation the Attorney General.

5. State and Subdivision Reporting

a) DHCS will prepare an annual written report regarding the State's use of funds from the settlement until those funds are fully expended and for one year thereafter. These reports will be made publicly available on the DHCS web site.

b) Each CA Participating Subdivision that receives payments of funds from the settlement will prepare written reports at least annually regarding the use of those funds, until those funds are fully expended and for one year thereafter. These reports will also include a certification that all funds that the CA Participating Subdivision has received through the settlement have been used in compliance with the Distributor Settlement Agreement and this CA Distributor Allocation Agreement. The report will be in a form reasonably determined by DHCS. Prior to specifying the form of the report DHCS will confer with representatives of the Plaintiff Subdivisions.

c) The State and all CA Participating Subdivisions receiving CA Abatement Accounts Funds will track all deposits and expenditures. Each such subdivision is responsible solely for the CA Abatement Accounts Funds it receives. A county is not responsible for oversight, reporting, or monitoring of CA Abatement Accounts Funds received by a city within that county that receives direct payment. Unless otherwise exempt, Subdivisions' expenditures and uses of CA Abatement Accounts Funds and other Settlement Funds will be subject to the normal budgetary and expenditure process of the Subdivision.

d) Each Plaintiff Subdivision receiving CA Subdivision Funds will track all deposits and expenditures, as required by the Distributor Settlement Agreement and this CA Distributor Allocation Agreement. Among other things, Plaintiff Subdivisions using monies from the CA Subdivision Fund for purposes that do not qualify as Opioid Remediation must identify and include in their annual report, the amount and how such funds were used, including if used to pay attorneys' fees, investigation costs, or litigation costs. Pursuant to Section V(B)(2) of the Distributor Settlement Agreement, such information must also be reported to the Settlement Fund Administrator and the Distributors.

e) In each year in which DHCS prepares an annual report DHCS will also host a meeting to discuss the annual report and the Opioid Remediation activities being carried out by the State and Participating Subdivisions.

6. Miscellaneous

a) The State or any CA Participating Subdivision may bring a motion or action in the court where the State has filed its Consent Judgment to enforce the requirements of this CA Distributor Allocation Agreement. Before filing such a motion or action the State will meet and confer with any CA Participating Subdivision that is the subject of the anticipated motion or action, and vice versa.

b) Except as provided in the Distributor Settlement Agreement, this CA Distributor Allocation Agreement is not enforceable by any party other than the State and the CA Participating Subdivisions. It does not confer any rights or remedies upon, and shall not be enforceable by, any third party.

c) Except as provided in the CA Distributor Allocation Agreement, if any provision of this agreement or the application thereof to any person, entity, or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this agreement, or the application of such provision to persons, entities, or circumstances other than those as to which it is invalid or unenforceable, will not be affected thereby, and each other provision of this agreement will be valid and enforceable to the fullest extent permitted by law.

d) Except as provided in the Distributor Settlement Agreement, this agreement shall be governed by and interpreted in accordance with the laws of California.

APPENDIX 2

Cost Reimbursement Procedure

1. Additional defined terms:

a) *Costs* means the reasonable amounts paid for the attorney and other City Attorney and County Counsel staff time for individuals employed by a Plaintiff Subdivision at the contractual rate, inclusive of benefits and overhead, together with amounts paid for court reporters, experts, copying, electronic research, travel, vendors, and the like, which were paid or incurred (i) prior to July 21, 2021 in litigation against any Opioid Defendant and/or (ii) in negotiating and drafting this CA Distributor Allocation Agreement. Costs does not include attorneys' fees, costs, or expenses incurred by private contingency fee counsel. No part of the CA Abatement Accounts Fund will be used to reimburse Costs.

b) *First Claims Date* means October 1, 2023 or when all applications for reimbursement of Costs, in whole or in part, from funds available under Section X and Exhibit R of the Distributor Settlement Agreement or Section XI and Exhibit R of the Janssen Settlement Agreement, have been finally determined under the provisions of those agreements, whichever comes first.

c) *Special Master* means a retired judicial officer or former public lawyer, not presently employed or retained by a Plaintiff Subdivision, who will aggregate, review, and determine the reasonable Costs to be awarded to each Plaintiff Subdivision that submits a claim for reimbursement of Costs. The Special Master will be selected by a majority vote of the votes cast by Plaintiff Subdivisions, with each such subdivision having one vote.

d) *Plaintiff Subdivision Committee* means the committee of Plaintiff Subdivisions that will review and approve the invoices submitted by the Special Master reflecting his or her reasonable time and expenses.

2. Cost Reimbursement to Plaintiff Subdivision

a) Purpose. Substantial resources have been expended to hold Opioid Defendants accountable for creating and profiting from the opioid crisis, and this effort has been a significant catalyst in creating a National Opioid Settlement with Distributors, Johnson & Johnson, and others.

b) Claims Procedure.

i. If a Plaintiff Subdivision is eligible to seek reimbursement of Costs, in whole or in part, from funds available under Section X or Exhibit R of the Distributor Settlement Agreement or Section XI or Exhibit R of the Janssen Settlement Agreement, it must first make a timely application for reimbursement from such funds. To allow sufficient time for determination of those applications, no claim for

Costs to the CA Subdivision Fund under this Agreement may be made before the First Claims Date.

ii. A Plaintiff Subdivision that wishes to be reimbursed from the CA Subdivision Fund must submit a claim to the Special Master no later than forty-five (45) days after the First Claims Date. The Special Master will then compile and redistribute the aggregated claim totals for each Plaintiff Subdivision via email to representatives of all the Plaintiff Subdivisions. A claim for attorney and staff time must list, for each attorney or staff member included in the claim, the following information: name, title, total hours claimed, hourly rate (including, if sought, benefits and share of overhead), and narrative summarizing the general nature of the work performed by the attorney or staff member. For reimbursement of "hard" costs, the subdivision may aggregate across a category (e.g., total for travel costs). It is the intention of the Plaintiff Subdivisions that submission of documents related to reimbursement of Costs does not waive any attorney-client privilege or exemptions to the California Public Records Act.

iii. The Special Master may request, at his or her sole option, additional documents or details to assist in the final award of Costs.

iv. The Special Master will review claims for reasonableness and will notify each Plaintiff Subdivision of the final determination of its claim, and will provide a list of all final awards to all Plaintiff Subdivisions by email or, upon request, via First Class U.S. Mail. Any Plaintiff Subdivision may ask the Special Master to reconsider any final award within twenty-one (21) days. The Special Master will make a final determination on any such reconsideration request within thirty (30) days of receipt.

v. Any decision of the Special Master is final and binding, and will be considered under the California Arbitration Act, Code of Civil Procedure section 1280 et seq. as a final arbitration award. Nothing in this agreement is intended to expand the scope of judicial review of the final award for errors of fact or law, and the Parties agree that they may only seek to vacate the award if clear and convincing evidence demonstrates one of the factors set forth in Code of Civil Procedure, section 1286.2, subdivision (a). Plaintiff Subdivisions will have fourteen (14) days after all final awards are made, together with any final determination of a request for reconsideration, to seek review in the Superior Court of California, pursuant to Code of Civil Procedure, section 1285, where the State has filed its Consent Judgment.

vi. The Special Master will prepare a report of Costs that includes his or her approved fees and expenses at least sixty (60) days before the Payment Date for each Annual Payment. The Special Master's preparation of a report of Costs does not discharge a Plaintiff Subdivision's reporting requirement under Section V.B.2 of the Distributor Agreement.

vii. A member of the Plaintiff Subdivision Committee, which is a CA Participating Subdivision, will submit to the Settlement Fund Administrator and the Distributors a

report of the fees and expenses incurred by the Special Master pursuant to Section V.B.2 of the Distributor Agreement.

c) Claims Priority and Limitation.

i. The Special Master will submit invoices for compensation of reasonable fees and expenses to the Plaintiff Subdivision Committee no later than sixty (90) days prior to the Payment Date for each Annual Payment. The Plaintiff Subdivision Committee will promptly review and, if reasonable, approve the Special Master's invoice for compensation. The Plaintiff Subdivision Committee will submit approved invoices to the Settlement Fund Administrator for payment. The Special Master's approved invoices have priority and will be paid first from the CA Subdivision Fund before any award of Costs, subject to the limitation in Section 2.c.v below.

ii. Final Awards of Costs that do not exceed seventy-five thousand dollars ($75,000.00) will be paid next in priority after the Special Master's approved invoices.

iii. Final Awards of Costs in excess of seventy-five thousand dollars ($75,000.00) will be paid proportionally from the funds remaining in that year's Annual Payment.

iv. Any claim for Costs that is not paid in full will be allocated against the next year's distribution from the CA Subdivision Fund, until all approved claims for Costs are paid in full.

v. In no event will more than 50% of the total CA Subdivision Fund received in any year be used to pay Costs or the Special Master's approved invoices.

vi. In no event shall more than $28 million of the total CA Subdivision Funds paid pursuant to the Distributor Settlement Agreement and the Janssen Settlement Agreement be used to pay Costs.

d) Collateral Source Payments and Third-Party Settlement.

i. In the event a Plaintiff Subdivision is awarded compensation, in whole or in part, by any source of funds created as a result of litigation against an Opioid Defendant for its reasonable Costs, it will reduce its claim for Costs from the CA Subdivision Fund by that amount. If a Plaintiff Subdivision has already received a final award of Costs from the CA Subdivision Fund, it will repay the fund up to the prior award of Costs via a payment to the Settlement Fund Administrator or notify the Settlement Fund Administrator that its allocation from the next and subsequent Annual Payments should be reduced accordingly. If the Plaintiff Subdivision is repaying any prior award of Costs, that repayment will occur as soon as is feasible after the Plaintiff Subdivision's receipt of Cost funds from the collateral source, but no more than 90 days after its receipt from the collateral source. The Settlement Fund Administrator will add any repaid Costs to the CA Subdivision Fund.

ii. In the event a Plaintiff Subdivision reaches a monetary settlement or compromise against any Opioid Defendant outside of the National Opioid Settlement, the monetary portion of such settlement, net of fees paid to outside contingency fee counsel and of funds earmarked strictly for abatement, will be credited against its Costs and the subdivision will be ineligible to recover those credited Costs from the CA Subdivision Fund. Plaintiff Subdivisions negotiating monetary settlements or compromises against any Opioid Defendant outside of the National Opioid Settlement will negotiate for funds to repay any Costs it previously received from the CA Subdivision Fund or for Costs it otherwise might be eligible to claim from the CA Subdivision Fund. If such a settlement is paid after all final approved claims for Costs by all Plaintiff Subdivisions are satisfied in full, the settling subdivision will reimburse the CA Subdivision Fund in that amount by making payment to the Settlement Fund Administrator to add to the CA Subdivision Fund in a manner consistent with the repayments described in section 2.d.i above.

EXHIBIT C

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.