



Christian County Commission

100 West Church St, Room 100
Ozark, MO 65721

SCHEDULED

MEETING ATTACHMENTS (ID # 5567)

Meeting: 08/28/26 8:00 AM

Department: County Clerk

Category: Meeting Items

Prepared By: Zoey Strong

Initiator: Zoey Strong

Sponsors:

Doc ID: 5567

Meeting Attachments

ATTACHMENTS:

- 1 - COVER SHEET
- 2 - 28 AUGUST 2026 - COMMISSION AGENDA - OPIOID SETTLEMENT DISCUSSION
- 3 - 28 AUGUST 2026 - ESSENTRIFY OPIOID CRISIS BREIFING
- 4 - 28 AUGUST 2026 - OPIOID SETTLEMENT PROPOSALS
- 5 - 28 AUGUST 2026 - OPIOID FUND ALLOWABLE USES
- 6 - 28 AUGUST 2026 - OPIOID REMEDIATION USES
- 7 - 28 AUGUST 2026 - SETTLEMENT FUNDS 2022-2026
- 8 - 28 AUGUST 2026 - SETTLEMENT FUNDS THROUGH 2028
- 9 - 28 AUGUST 2026 - SUMMARY OF NATL. SETTLEMENTS



Christian County Commission

100 West Church St, Room 100

Ozark, MO 65721

Work Session - Opioid Settlement Programs

Presiding Commissioner Lynn Morris

We would like to hold another work session to begin developing our program(s) to focus on problems associated with narcotics and alcohol.

At this time, we would like to meet and discuss ideas for programs that could benefit our citizens and the county. If possible, participants will come prepared to share their proposed program concepts, along with an estimated annual cost. We will review and discuss these ideas to determine which projects we might begin working on together.

At this meeting, we will provide current balances for our opioid settlement accounts, as well as projected annual revenues for the remainder of the settlement period through 2038.

This meeting will be held on Friday, August 28th, beginning at 8:00 am at the Commission office. One or more Commissioners may be present.



Christian County Commission

100 W. Church Street Room 100
Ozark, Missouri 65721
(417)582-4300

Lynn Morris
Presiding Commissioner

Bradley A. Jackson
Eastern Commissioner

Johnny Williams
Western Commissioner

August 28, 2026
8:00 am

OPIOID SETTLEMENT FUNDS DISCUSSION

This is a work study instead of a Commission Meeting

AGENDA

Call the meeting to Order

Self-Introduction of attendees

Recap / Financial Update of the Opioid Accounts
Restricted vs Unrestricted

What projects should be considered?
Presentation of each proposed program and concepts

September 3rd Commission Meeting – Discussion of Opioid Settlement Money

- a. How many programs?
- b. Cost per program – Money spent annually?
- c. Application Process
- d. Goal – Start programs 2027

Additional topics to discuss?

I would like to have another meeting before the end of September / 1st October.

Comments / Questions?

Adjourn

Proposal for Funding Urinalysis and Educational Programming Costs for Diversion Program Participants

To: Christian County Commissioner's Office

From: Christian County Prosecuting Attorney's Office

Date: 8/28/2026

Subject: Request to Utilize Opioid Settlement Funds to Cover Urinalysis and Educational Programming Costs for Diversion Program Participants.

Purpose

The purpose of this proposal is to request Christian County opioid settlement money to cover the costs of required urinalysis and educational programming for participants in the newly developing Christian County Diversion Program. Providing financial assistance would help remove a potential barrier to successful program participation while maintaining accountability and monitoring requirements of the prosecutor's office.

Background

Diversion Programs provide eligible individuals with an opportunity to address underlying issues contributing to their involvement in the criminal justice system, while holding individuals accountable for their actions. Regular drug testing and educational programming are important components of the program. Urinalysis allows the Diversion Program's team to monitor compliance, identifying potential substance-use concerns, and respond appropriately to additional intervention if required. Educational programming allows for the program to address underlying criminal thinking behaviors.

The cumulative cost of required testing and educational programming will create a financial hardship for many participants. Those costs may compete with participants' basic necessities such as housing, transportation, food and other treatment expenses. In some cases, the added financial burden may discourage participation or create an additional obstacle for those who are otherwise making meaningful progress in the program.

Funding Request and Fiscal Considerations

The proposed funding would:

- Cover required urinalysis and programming costs for participants.

- Ensure that financial hardship does not prevent or interfere with compliance within the program.
- Maintain consistent and reliable monitoring of Diversion Program conditions.
- Support community-based participant accountability.
- Reduce barriers that may contribute to program failure or reentry into the criminal justice system.

The requested allocation can be structured to provide assistance based on program participation need. The Diversion Program staff will maintain records of expenses and provide periodic expenditure reports to ensure transparency and fiscal responsibility. Although, it is difficult to anticipate the number of participants at this time, records that are kept will determine the average cost of testing per participant and moving forward this would allow the Prosecuting Attorney and the Commissioner's Office to evaluate future expenditures.

The following are costs based on having 200 participants through 2027:

Oral saliva onsite testing by the Diversion Court staff: \$124 per box of 25 ct. \$1120 would cover this cost through 2027.

Urinalysis testing by an off-site organization: \$25 per test. \$6000 would cover this cost.

Educational programming referred to a community-based organization: \$50,000 would cover this cost.

Conclusion

Required urinalysis and educational programming is an essential accountability component of a Diversion Program. Participants must be held responsible for their actions, and they need to be compliant with program requirements. However, the financial requirements should not become an insurmountable barrier to successful completion.

We respectfully request that the Christian County Commissioner's Office consider allocating opioid settlement funds to cover costs for eligible Diversion Program participants. This investment would strengthen the program's ability to monitor compliance, support treatment and rehabilitation, lower county recidivism rates and promote successful outcomes for participants while serving the broader interests of Christian County.

Respectfully,

Christian County Prosecuting Attorney's Office
Diversion Program



The Opioid Crisis Is Not a Policy Problem.

It is a generational wound carried by individuals, hollowing out families, and fracturing communities that depend on your leadership.

80,000+

Overdose deaths annually in the U.S.

CDC, 2023

2,131

Missourians lost in a single year

CDC, Oct 2020–Oct 2021

\$1T+

Annual economic burden in the U.S.

NIH Estimate

The Weight of This Crisis

Behind every statistic is a human story — and a structural failure.

Communities didn't choose this crisis. They were handed it. And now they are expected to solve it alone, under-resourced, and under-equipped.

Rural counties watch their workforce dissolve. Emergency departments operate at capacity. Children enter foster care in record numbers.

This is not a local failure. It is a national emergency at the doorstep of every county commissioner in America.

01 Ages 25–34

The Young Adult

Highest overdose death rate nationally. Often first prescribed opioids for a legitimate reasons like surgery, injury, dental work. Addiction restructures brain chemistry; recovery demands sustained clinical support most individuals cannot access without structured community programs.

02 Families

The Parent

Millions of children raised by grandparents or in foster care because a parent's addiction led to custody loss before loss of life. Families absorb the treatment burden without training, resources, or relief, straining marriages and depleting generational wealth.

03 Rural Areas

The Rural County

Missouri's most vulnerable counties: fewest mental health providers per capita, longest distances to care, least economic diversity. The downstream cost lands on every county causing reduced workforce, strained courts, overwhelmed emergency infrastructure.



The Money Arrived. The Impact Didn't.

\$50B+ in national opioid settlements. Missouri alone: ~\$900M over 18 years. Yet in 2023, 68% of local governments spent \$0.

68%

of MO local governments
spent \$0 in 2023

MO DMH Annual Report, 2024

01 Fiscal Inertia

Funds Collecting Interest

Funds not in use collect interests. That's technically prudent, functionally useless for people who need care.

02 Legal Ambiguity

Unclear Allowable Use

Exhibit E approved-use lists requires combining legal and clinical requirements that may be difficult to interpret. Without clarity, cautious decision making often leads to inaction.

03 Fear of Audit

Personal Liability

Forensic audits and aligned 42 CFR Part 2 / HIPAA enforcement are fully active. County officials and grant managers face personal exposure if funds are misspent.

04 Evidence Gap

Misaligned Spending

Some counties spend, but without outcome documentation, clawbacks are real. Without an evidence infrastructure, spending is as dangerous as sitting still.

⚠ The Real Consequence: When innovators can't access funds, settlement dollars don't just sit idle, they fail to generate evidence. Every dollar undeployed is data never collected, a program never tested, a proof point never built. The evidence-based approach to fighting the opioid crisis is lost before it begins.

[Draft] Fw: Work Study Session on Opioid Settlement Funds

From bporterfield@christiancountymo.gov

Draft saved Wed 8/26/2026 4:10 PM

 3 attachments (533 KB)

Approved uses of opioid funds.pdf; Opioid Fund Allowable Uses.pdf; Proposals for Opioid Funding.docx;

From: Laura.Johnson@courts.mo.gov

Date: August 26, 2026 at 2:25:57 PM CDT

To: Lynn Morris <lmorris@christiancountymo.gov>, Johnny Williams <jwilliams@christiancountymo.gov>, Bradley Jackson <bjackson@christiancountymo.gov>

Subject: Work Study Session on Opioid Settlement Funds

Caution: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Gentlemen: In light of the upcoming work study session on the use of opioid settlement funds, I am attaching the guidelines for use of the funds. I am also attaching information regarding proposals for funds for Christian County Treatment Court and a Christian County sober living facility.

I appreciate your interest in supporting efforts to reduce the impact of opioids and other substances on our community. Thank you.

(See attached file: Approved uses of opioid funds.pdf) (See attached file: Opioid Fund Allowable Uses.pdf) (See attached file: Proposals for Opioid Funding.docx)

Laura Johnson
Presiding Circuit Judge
38th Judicial Circuit
(417) 582-5162

PROPOSALS FOR OPIOID SETTLEMENT FUNDS

Christian County Treatment Court

Treatment Court is an effective, evidence-based treatment program for high risk, high need substance addicted criminal offenders. The participants in treatment court have a long history of addiction to opioids and other substances. Because treatment court is a very intense treatment program, many participants graduate successfully even though they have failed to be successful in other treatment programs. Below is a list of treatment courts operated by Christian County with the number of current participants:

Drug Court	20
DWI Court	27
Co-occurring Court	16
Veterans' Court	12
Total	75

We hope to add a Family Drug Court.

There are several reasons why people who would otherwise qualify for treatment court are not able to participate, including the lack of transportation and lack of housing. Many of our participants are also in desperate need of medical, mental health and dental treatment. Untreated physical, mental and dental conditions are a huge obstacle to recovery. Additionally, participants cannot afford to license their vehicles, obtain their GED, return to school, etc. A participant assistance fund would allow treatment court to provide Uber gift cards, deposits for sober living facilities or other housing, physical and mental treatment, necessities such as clothing and hygiene items, repair and license vehicles, obtain their GED or attend vocational or college classes.

This year all treatment courts statewide received a significant cut in budgeted funding for next year. The Christian County budget for FY26 is \$211,264.28, but the budget for FY27 is \$183,852.01, for a reduction of \$27,412.27. We have found the state budget does not allow expansion of our treatment courts.

Proposals for Treatment Court:

1. Annual supplement of treatment county budget: \$40,000/year
2. Participant assistance fund: \$10,000/year
3. Family Drug Court: \$10,000 one-time commitment to begin program

Christian County Sober Living Facility—Common Solutions

Common Solutions is the only sober living program offered in Christian County. Many of our substance addicted defendants reside at Common Solutions. It is operated by Jimmy Smothers. Common Solutions is very important to Christian County's response to opioid and substance addiction.

Proposals for Common Solutions:

1. Two preowned vehicles for transportation of residents: \$80,000
2. Repair and maintenance of facilities: to be determined

Emails from other counties on use of settlement funds

From: Joseph Purschke/20/Courts/Judicial
To: Jim D Beck/45/Courts/Judicial@JUDICIAL, Laura Johnson/38/Courts/Judicial@JUDICIAL
Date: 02/10/2026 10:45 AM
Subject: Opioid Settlement Funding

Good morning,

Here in Franklin County, with cooperation of our commissioners, we divide the proceeds up among the local stakeholders in the non-profit recovery community.

PreventEd which funds a Certified Peer Support program for our area,

Foundations for Franklin County, a drug prevention/education program for youth.

"CRUSH" is an annual teen drug summit education program,

Franklin County Alternative Court programs, (Drug Court, DWI Court, Co-Occurring Court, Family Treatment Court)

We've added two caseworkers to augment the supervision component of our treatment courts, effectively expanding our services to 70 additional participants.

Franklin County Sheriffs Department has used funds to support officer liaisons provided to our treatment courts and to provide drug related medical services in the jail.

In Gasconade County, funding is used to help support a nonprofit that provides sober living houses.

I'd be happy to talk more about this if you have any questions,

Thanks,

Judge Joe

From: Lori Jones/44/Courts/Judicial
To: Laura Johnson/38/Courts/Judicial@JUDICIAL
Date: 02/11/2026 12:34 PM
Subject: Opioid Funds Utilized in Wright County

We have given money to the Pregnancy Resource Center, aided in purchasing a van for a sober living program (paid to the dealership), paid for SIM Workshop lunch, given money to Sheriff's Department to help purchase Nartec, pay for a portion of Omnigo to aid in tracking cases, reimburse for CIT Training and a portion of wages to keep them on staff that can identify OUD and SUD/MH to obtain help and services.

We were also going to allocate some of the funds to aid in the down payment of a house for a sober living home, but that was never done due to the home catching on fire prior to the sale becoming final.

Lori Jones

Wright County Circuit Clerk
P.O. Box 39
Hartville, MO 65667
Ph-417-741-7121 ext. 239
Fax 417-741-7120

From: Zac Horack/33/Courts/Judicial
To: Jim D Beck/45/Courts/Judicial@JUDICIAL
Cc: Laura Johnson/38/Courts/Judicial@JUDICIAL
Date: 02/11/2026 02:45 PM
Subject: Re: Question re programs for defendants with substance abuse disorder

We've had success using funds to support our pretrial program - transportation for drug related offenders, treatment program fees, pretrial training/conferences for staff, urinalysis cups, etc.

Hope that helps!
-Zh

Zac Horack
Presiding Circuit Judge
33rd Judicial Circuit
Post Office Box 418
Benton, Missouri 63736
Office: (573) 545-3141
Fax: (573) 545-3000

ALLOWABLE USE LIST	ALLOWABLE USE CATEGORY	REPORTING CODE
PART 1 - TREATMENT		
A	Treat Opioid Use Disorder (OUD)	1-A
B	Support people in Treatment and Recovery	1-B
C	Connections to Care (connect people who need help to the appropriate services)	1-C
D	Address the needs of criminal justice-involved persons	1-D
E	Address the needs of pregnant or parenting women and their families, including babies with NAS	1-E
PART 2 - PREVENTION		
F	Prevent over-prescribing of opioids and ensure appropriate prescribing & dispensing of opioids	2-F
G	Prevent misuse of opioids	2-G
H	Harm Reduction (prevent OD deaths and other harms)	2-H
PART 3 - OTHER OPIOID ABATEMENT STRATEGIES		
I	First Responders	3-I
J	Leadership, Planning, and Coordination	3-J
K	Training	3-K
L	Research	3-L

*Source for above - Exhibit E, Schedule B, Approved Uses for opioid remediation
(Settlement final agreement documents)*

PART 4 - OTHER USES		
	Administrative costs related to settlement distribution	4-M
	Attorney's fees	4-N
	Other use not included above	4-O
PART 5 - NONE		
	No expenditures from Opioid Settlement funds this CY	5-P
PART 6 - PAYMENT TO STATE		
	Received Opioid Settlement funds Amount of payment sent to the State of MO this CY	6-Q

Note - any use of funds for non-approved purposes are subject to separate reporting requirements directly to the settlement administrator.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART ONE: TREATMENT		
A. TREAT OPIOID USE DISORDER (OUD)		
Support treatment of 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:		
1-A	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 (FDA).
1-A	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.
1-A	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 services.
1-A	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.
1-A	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.
1-A	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.
1-A	7	Support evidence-based withdrawal management services for people with OUD and any co-occurring MH conditions.
1-A	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 tele-mentoring to assist community-based providers in rural or underserved areas.
1-A	9	Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
1-A	10	Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
1-A	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.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART ONE: TREATMENT - CONTINUED		
1-A	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.
1-A	13	Disseminate 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.
1-A	14	Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for MAT.
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-B	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.
1-B	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.
1-B	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.
1-B	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 medication with other support services.
1-B	5	Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
1-B	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.
1-B	7	Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART ONE: TREATMENT - CONTINUED		
1-B	8	Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
1-B	9	Identify successful recovery programs such as physician, pilot, college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
1-B	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.
1-B	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.
1-B	12	Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
1-B	13	Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
1-B	14	Create and/or support recovery high schools.
1-B	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, those that:		
1-C	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.
1-C	2	Fund SBIRT (Screening, Brief Intervention and Referral to Treatment) programs to reduce the transition from SUD/ODs, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
1-C	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.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART ONE: TREATMENT - CONTINUED		
1-C	4	Purchase automated versions of SBIRT and support ongoing costs of the technology.
1-C	5	Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
1-C	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.
1-C	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.
1-C	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.
1-C	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.
1-C	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.
1-C	11	Expand warm hand-off services to transition to recovery services.
1-C	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.
1-C	13	Develop and support best practices on addressing OUD in the workplace.
1-C	14	Support assistance programs for health care providers with OUD.
1-C	15	Engage non-profits and the faith community as a system to support outreach for treatment.
1-C	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.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART ONE: TREATMENT - CONTINUED		
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-D	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.
1-D	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.
1-D	3	Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.
1-D	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.
1-D	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.
1-D	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.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART ONE: TREATMENT - CONTINUED		
1-D	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-E	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 NAS.
1-E	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.
1-E	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.
1-E	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.
1-E	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.
1-E	6	Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.
1-E	7	Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.
1-E	8	Provide enhanced support for children and family members suffering from trauma as a result of OUD/SUD in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART ONE: TREATMENT - CONTINUED		
1-E	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.
1-E	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.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART TWO: PREVENTION		
F. PREVENT OVER-PRESCRIBING & ENSURE APPROPRIATE PRESCRIBING & 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:		
2-F	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 CDC, including providers at hospitals (academic detailing).
2-F	2	Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
2-F	3	Continuing Medical Education (CME) on appropriate prescribing of opioids.
2-F	4	Providing support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
2-F	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.
2-F	6	Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the USDOT's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
2-F	7	Increasing electronic prescribing to prevent diversion or forgery.
2-F	8	Educating dispensers on appropriate opioid dispensing.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART TWO: PREVENTION - CONTINUED		
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:		
2-G	1	Funding media campaigns to prevent opioid misuse.
2-G	2	Corrective advertising or affirmative public education campaigns based on evidence.
2-G	3	Public education relating to drug disposal.
2-G	4	Drug take-back disposal or destruction programs.
2-G	5	Funding community anti-drug coalitions that engage in drug prevention efforts.
2-G	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).
2-G	7	Engaging non-profits and faith-based communities as systems to support prevention.
2-G	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.
2-G	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.
2-G	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.
2-G	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.
2-G	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.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART TWO: PREVENTION - CONTINUED		
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:		
2-H	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-H	2	Public health entities providing free naloxone to anyone in the community.
2-H	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.
2-H	4	Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
2-H	5	Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.
2-H	6	Public education relating to emergency responses to overdoses.
2-H	7	Public education relating to immunity and Good Samaritan laws.
2-H	8	Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.
2-H	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.
2-H	10	Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
2-H	11	Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.
2-H	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.
2-H	13	Supporting screening for fentanyl in routine clinical toxicology testing.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART THREE: OTHER OPIOID ABATEMENT STRATEGIES		
I. FIRST RESPONDERS		
In addition to the items in section C, D and H relating to first responders, support the following:		
3-I	1	Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
3-I	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:		
3-J	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.
3-J	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-J	3	Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing 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.
3-J	4	Provide resources to staff government oversight and management of opioid abatement programs.

DETAILED LIST OF APPROVED USES FOR OPIOID REMEDIATION
Source - national settlement final agreement documents – Exhibit E, Schedule B

Approved Use Section	Approved Use Subsection	Description
PART THREE: OTHER OPIOID ABATEMENT STRATEGIES - CONTINUED		
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:		
3-K	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.
3-K	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:		
3-L	1	Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.
3-L	2	Research non-opioid treatment of chronic pain.
3-L	3	Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to OUD.
3-L	4	Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
3-L	5	Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
3-L	6	Expanded research on swift/certain/fair models to reduce and deter opioid approaches used to address other substances (e.g., Hawaii HOPE and Dakota 24/7).
3-L	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.
3-L	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.
3-L	9	Geospatial analysis of access barriers to MAT and its association with treatment engagement and treatment outcomes.

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 medication 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 (“*PAARF*”);
 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 (“CTP”), 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.

Opioid Settlement Funds Received - 2022 thru 2026

Companies	2022	2022-2	2023	2024	2024-2	2025	2025-2	2026	TOTAL
Allergan (July)				\$15,468.21	\$15,456.21	\$15,076.86	\$0.00	\$15,076.86	61,078.05
CVS (July)				\$15,523.77	\$11,976.68	\$26,552.14	\$0.00	\$26,552.14	80,604.73
Misc. Distributors (July)	\$33,829.40	\$35,553.05	\$22,665.08	\$37,323.56	24,731.49	\$37,336.97	\$0.00	\$37,336.97	228,776.52
Janssen (June)	\$12,043.48	\$28,097.69	\$22,447.58	\$35,667.69	14,427.39	\$39,621.48	\$0.00	\$4,941.90	157,247.21
Kroger (April)				0.00	0.00	\$5,475.55	\$5,475.55	5,475.55	16,426.65
Teva (July)				\$13,544.22	\$13,556.44	\$13,005.79	0.00	\$13,005.79	53,112.24
Walgreens (April)				\$23,638.36	\$11,496.57	\$11,496.57	0.00	\$10,762.91	57,394.41
Walmart (August)				\$140,399.57	0.00	\$1,196.59	0	\$1,196.59	142,792.75
TOTALS	45,872.88	63,650.74	45,112.66	281,565.38	91,644.78	149,761.95	\$5,475.55	114,348.71	797,432.56

CURRENT BALANCES as of 8/11/2026

Unrestricted	97,123.28
Restricted	699,112.69
TOTAL as of 8/11/2026	796,235.97
remaining due for 2026	1,196.59
	797,432.56

Opioid Settlement Funds - To Date and Expected thru 2038

Companies	2026		2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	TOTAL
Allergan (July)	*15,076.86		18,127.26	18,127.26	18,127.26										54,381.78
CVS (July)	*26,552.14		26,552.14	32,100.75	30,496.98	28,893.22	28,867.77	28,867.77							175,778.63
Misc. Distributors (July)	*37,336.91		28,665.93	57,396.77	57,396.77	57,396.77	48,247.78	48,247.78	48,247.78	48,247.78	48,247.78	48,247.78	48,247.78	48,247.78	586,838.48
Janssen (June)	*4,941.9		4,941.90	4,941.90	9,592.22	9,592.22	9,592.22								38,660.46
Kroger (April)	*5,475.55		5,475.55	5,475.55	6,002.76	6,662.78	6,662.78	6,662.78	6,662.78	6,662.78					50,267.76
Teva (July)	*13,005.79		13,005.79	13,005.79	16,384.05	16,384.05	16,384.05	16,384.05	16,384.05	16,384.05	16,384.05				140,699.93
Walgreens (April)	*10,762.91		10,762.91	10,762.91	10,762.91	23,638.36	23,638.36	23,638.36	23,638.36	23,638.36	23,638.36	23,638.36	23,638.36		221,395.61
Walmart (August)	1,196.59		1,196.59	1,196.59											2,393.18
TOTALS	114,348.65		108,728.07	143,007.52	148,762.95	142,567.40	133,392.96	123,800.74	94,932.97	94,932.97	88,270.19	71,886.14	71,886.14	48,247.78	1,270,415.83
	* rec'd for 2026														

CURRENT BALANCES as of 8/11/2026	
Unrestricted	97,123.28
Restricted	699,112.69
TOTAL as of 8/11/2026	796,235.97
remaining due for 2026	1,196.59
	797,432.56
plus expected funds	1,270,415.83
Expected TOTAL funds	2,067,848.39

SUMMARY OF NATIONAL SETTLEMENTS

Maximum Missouri amounts listed as of October 1, 2025. Information is subject to change, as all settlements are not final.

State & Local Totals	Settlements/Companies	Payment Length	Final Year
\$370 million	DISTRIBUTORS   	18 years	through 2038
\$84 million	JANSSEN 	10 years	through 2031
\$101 million	WALGREENS 	15 years	through 2037
\$92 million	CVS 	10 years	through 2032
\$52 million	WALMART 	5 years	through 2028
\$70 million plus \$29 million	TEVA 	13 years Product Value	through 2035
\$42 million	ALLERGAN 	7 years	through 2029
\$11.7 million (state) \$3.4 million (locals)	MCKINSEY 	5 years 1 time	through 2025
\$6.9 million (state)	PUBLICIS HEALTH 	1 time	2024
\$6.6 million (state)	ENDO 	1 time	2024
\$5.9 million (state) \$1 million (locals)	MALLINCKRODT 	2 years 1 time	2023 & 2025 TBD
\$25 million (estimate)	KROGER 	11 years	through 2034
\$91 million (estimate) TBD	PURDUE DIRECT PURDUE BANKRUPTCY 	15 years TBD	TBD TBD
\$14 million (estimate)	SMALL MANUFACTURERS        	10 years	TBD