City of Biddeford
Policy Committee

August 26, 2024 at 6:00 PM
City Hall Council Chambers & Zoom

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Meeting ID: 983 0525 0879
Passcode: 404528

1. Roll Call
2. Pledge of Allegiance
3. Adjustment(s) to Agenda
4. Approval of Minutes
5. Discussion/Review
   - 5.a Orchard Street Parking
   - 5.b Amend/ Part II: Code of Ordinances, Chapter 42 Motor Vehicles and Traffic, Article IV Specific Street Regulations, Sec. 42-90(a) No Parking - Lester B. Orcutt Blvd
   - 5.c Amended Opioid Use Settlement Ordinance
   - 5.d Transfer Station Fees
6. Adjourn

Policy Committee

Meeting Date:	August 26, 2024
Meeting Time:	6:00 PM
Agenda Item No:	5.a
Item Description:	Orchard Street Parking
Submitted By:	JoAnne W. Fisk, Chief of Police

Supporting Information/Documentation:
Orchard Street Pavement Widths

Key Terms:

Executive Summary:
A request from several Orchard Street residents was forwarded to Staff from Council President Liam Lafountain. Residents have requested an elimination of parking on one side of the roadway due to safety concerns. At 25.65 and or 28.65 feet of road width, vehicles parked opposite each other on Orchard Street would not allow for free and unencumbered passage of vehicles traveling in an east/west direction, including that of larger emergency fire vehicles.

Detailed Review:
Orchard Street is a residential street 1069 feet ± in length, varying in road width from 25.65 ft on the Elm Street end to 28.65 ft on the May Street end. The current parking restriction under City Ordinance Sec. **42-90(a) No Parking** (a) There shall be no parking on the following streets for the specified distance:

- Orchard Street, northeasterly (even-numbered) side, from Elm Street to a distance of 300 feet
- Orchard Street, odd-numbered side, from Elm Street, a distance of 300 feet, being the crest of the small incline at the driveway entry

Funding Source:
The funding source is DPW signage budget.

Staff Recommendation:

Passage of Limited parking under City Ordinance **42-92(a) Limited Parking: Parking will be limited at the following locations in the specified manner:** Orchard Street parking on the odd-numbered side of the street only, beginning at Elm Street intersection, 1069 ft. ± westerly to intersection of May Street.


28.65'
28.20'
26.75'
25.65'
May St
Orchard St
Lamothe Ave
Lessard Ave
Pelletier roofing
Mcarthur
Cherry Ln
Elm St
Union St
Sisters Immaculate Heart Mary
JBC WOOD FLOORS
Google

Policy Committee

Meeting Date: August 26, 2024
Meeting Time: 6:00 PM
Agenda Item No: 5.b
Item Description: Amend/ Part II: Code of Ordinances, Chapter 42 Motor Vehicles and Traffic, Article IV Specific Street Regulations, Sec. 42-90(a) No Parking - Lester B. Orcutt Blvd
Submitted By:

Supporting Information/Documentation:
20240827 Draft Order - Amend Sec 42-90(a) No Parking - Lester B. Orcutt Blvd

Key Terms:

Executive Summary:
This item reflects a request to add parking restrictions on Lester B. Orcutt Blvd to eliminate parking on the odd-numbered side of the street from the intersection with Ocean Ave westerly to approximately 340 feet before the intersection of First Street. An affirmative vote on this item will advance the amendment to the City Council for review and adoption.

Detailed Review:
Members of the City Council have requested review of parking on Lester B. Ocutt Boulevard in Biddeford Pool. Parking in the area is routinely observed to be congested with multiple complaints per year by residents and visitors related to pedestrian safety. The request is to eliminate parking on the odd-numbered side of the street from the intersection of Ocean Avenue westerly to approximately 340’ before the intersection of First Street. See the yellow line marked on the aerial map.

This change, if approved in the form presented, will require an ordinance amendment to Chapter 42-Motor Vehicles and Traffic, Article IV-Specific Street Regulations, Sec. 42-90(a) No Parking.

Funding Source:
N/A

Staff Recommendation:
This is a policy decision. Staff is not opposed to the requested change to eliminate parking on the odd-numbered side of the boulevard as requested. A draft of the Order is attached for review and if this item is approved it will be advanced to City Council for adoption in the form presented.

City of Biddeford

2024.## **IN BOARD OF CITY COUNCIL… {DATE}**

BE IT ORDAINED, that Part II: Code of Ordinances, Chapter 42 Motor Vehicles and Traffic, Article IV Specific Street Regulations, Sec. 42-90(a) No Parking, be amended by adding or ~~deleting~~ text as follow, Lester B. Orcutt Boulevard, odd-numbered side, from the intersection of Ocean Avenue westerly to approximately 340' before the intersection of First Street.

DRAFT

Attest by:_____

City of Biddeford Opioid Use Settlement Fund Tracking and Reporting Ordinance

Article I: Purpose and Title

1.1 This Ordinance shall be known as the "Opioid Use Settlement Fund Tracking and Reporting Ordinance".
1.2 The purpose of this Ordinance is to establish a transparent and accountable system for the management, tracking, and reporting of all revenues and expenses associated with the Opioid Use Settlement Fund in the City of Biddeford.

Article II: Establishment of a Dedicated Account

2.1 The City Manager or appropriate fiscal officer is hereby directed to establish a dedicated account, to be known as the "Opioid Use Settlement Fund."
2.2 All revenues received from opioid settlements or related activities shall be deposited directly into this separate account.
2.3 Expenses related to the opioid crisis or pursuant to the approved strategic plan as outlined in Article IV will be drawn from this account.

Article III: Use of Funds

3.1 All Opioid Use Settlement Funds shall be utilized solely to supplement and strengthen resources for the approved uses described herein. These uses include opioid use disorder prevention, harm reduction, treatment, and recovery.

3.2 The expenditure of Opioid Use Settlement Funds is strictly prohibited from being used to offset or supplant any existing or already budgeted expenditures. This includes any attempt to use opioid use settlement funds to replace or reduce funding for programs or services that are currently funded through other sources.

Article IV~~III~~: Reporting Requirements

~~3~~4.1 The Finance Director or appropriate fiscal officer shall provide a

detailed annual report to the City Council on the Opioid Use Settlement Fund by the 1st City Council meeting of September.

43.2 Each report shall include, at a minimum:
a) Total revenues received since the previous report.
b) A categorized list of all expenses made from the Fund since the previous report.
c) A summary of the current balance of the Fund.
d) Any other relevant information deemed necessary by the City Council.

Article IV: Strategic Planning

54.1 The City Council shall develop and approve adopt a strategic plan detailing the operational use of the Opioid Use Settlement Fund revenues by the 2nd City Council Meeting of November every two years. The City Council may direct city staff and/or a designated city committee to develop the strategic plan, which shall then be reviewed and approved by the City Council.

54.2 The strategic plan shall include:
a) Specific goals and objectives related to the use of the funds.
b) Detailed budget projections.
c) Expected outcomes and performance metrics.
d) Strategies for community engagement and input.

54.3 Any substantial changes or amendments to the strategic plan will require City Council approval.

54.4 Expenditures from the Opioid Use Settlement Fund exceeding **$10,000** or not explicitly approvedpermitted in the strategic plan or outside its scope must be approved by the City Council prior to disbursement.

Article VI: Implementation and Review

65.1 This Ordinance shall take effect thirty (30) days after its passage.

65.2 The City Council shall review the effectiveness of this Ordinance and make necessary amendments as deemed appropriate, but at a minimum, every two years coinciding with the strategic planning

process.
Passed this ___ day of _____**, 2024**.

MAINE STATE-SUBDIVISION MEMORANDUM OF UNDERSTANDING AND AGREEMENT REGARDING USE OF SETTLEMENT FUNDS-2023

Whereas, the people of the State of Maine and its communities have been harmed by misfeasance, nonfeasance and malfeasance committed by certain entities within the Pharmaceutical Supply Chain; and,

Whereas, the State of Maine, though its Attorney General, and certain Subdivisions, through their elected representatives and counsel, are separately engaged in litigation seeking tohold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misfeasance, nonfeasance and malfeasance; and,

Whereas, the State of Maine, through its Attorney General, and its Subdivisions share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance and malfeasance throughout the State of Maine;

Now therefore, the State and its Subdivisions, subject to completion of formal documents effectuating the Parties' agreements, enter into this Memorandum of Understanding ("MOU") relating to the allocation and use of the proceeds of Settlements described.

This agreement is subject to the requirements of the Subsequent Opioid Settlements, as defined herein, as well as applicable law. Terms used in this MOU have the same meaning as in those used in the Subsequent Opioid Settlements unless otherwise defined herein.

I. DEFINITIONS

A. "2022 State-Subdivision MOU" shall mean the agreement titled 'Maine State-Subdivision Memorandum of Understanding And Agreement Regarding Use of Settlement Funds', dated January 26, 2022 and as amended on June 13, 2022.

B. "Approved Uses" shall mean those uses identified in the List of Opioid Remediation Uses, attached as Exhibit E to the National Opioid Settlement, and those uses identified as "Approved Opioid Abatement Uses" in Schedules A and B to Exhibit G to the Noticeof Filing of Eighth Plan Supplement Pursuant to the Fifth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and its Affiliated Debtors, In re: Purdue Pharma L.P., et al., Case No. 19-23649-RDD, Dkt. 3121 (Bankr. S.D. N.Y. July 8, 2021), and attached as Exhibits I and 2 to the 2022 State-Subdivision MOU and attached hereto as Exhibits 1 and 2.

C. "Direct Share Subdivisions" means a plaintiff subdivision that has filed a complaint against a Pharmaceutical Supply Chain entity and/or a subdivision with a population equal to or greater than 10,000. For the avoidance of doubt, the 39 eligible Direct Share Subdivisions are as identified on Exhibit 3 hereto.

D. "Effective Date" means the first date on which a court of competent jurisdiction,

including any bankruptcy court, enters a Subsequent Opioid Settlement by order or consent decree.

E. The "Maine Recovery Fund" means the fund created by the 2022 State-Subdivision MOU, the funds of which will be used for the purposes of opioid abatement.

F. The "National Opioid Settlement" means the National Distributor and J&J Settlements Agreement, dated as of July 21, 2021, and any revision thereto.

G. "Opioid Funds" means all funds allocated by any Subsequent Opioid Settlement to the State or Direct Share Subdivisions for purposes of opioid abatement activities Not included are funds made available in any Subsequent Opioid Settlement for the payment of the Parties' litigation expenses or the reimbursement of the United States Government.

H. "Pharmaceutical Supply Chain" shall mean the process and channels through which Controlled Substances are manufactured, marketed, promoted, distributed or dispensed.

I. "Recovery Fund Council" means the Council created in Section III of the 2022 State-Subdivision MOU.

J. "Subsequent Opioid Settlement" means a statewide settlement reached with a non-bankrupt manufacturer of, distributor of, or pharmacy prescribing, opioids subsequent to the National Opioid Settlement pursuant to which certain Maine political subdivisions are eligible to participate and share in funds for opioid abatement ("Opioid Funds") in exchange for releases.

II. DISTRIBUTION OF FUNDS

A. **Applicability of Agreement.** Unless otherwise stated in this Agreement, these terms shall apply to any Subsequent Opioid Settlement.

B. **Approved Uses.** All Opioid Funds, regardless of allocation, shall be utilized for approved uses. The Parties in Section II.C are strongly encouraged to use Opioid Funds solely to supplement and strengthen, rather than supplant, resources for the approved uses described herein including for opioid use disorder prevention, harm reduction, treatment and recovery.

C. **Division of Funds.** All Opioids Funds allocated to the State of Maine and the Subdivisions are to be distributed as follows:

1. **20%** to the State of Maine Attorney General to be used on Approved Uses.

2. **30%** to the Direct Share Subdivisions for spending on Approved Uses to be allocated in accordance with Exhibit 3.

3. **50%** to be placed in the Maine Recovery Fund which are to be spent onApproved Uses as directed by the Recovery Council.

The Direct Share Subdivisions' shares shall be distributed directly to each Direct Share Subdivision by the National Settlement Administrator. Monies in the Maine Recovery Fund shall be distributed by the Treasurer of the State as described below. Any Direct Share Subdivision 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 their directshare distribution or funded by the Recovery Fund. Because the State did not hire outside counsel, any funds for attorney fees that the State receives from the Supplemental Opioid Settlements will be deposited into the Attorney General's share.

III. THE MAINE RECOVERY COUNCIL

The parties agree that the existing Maine Recovery Council, as established by Section III of the 2022 State-Subdivision MOU, shall administer payments made to the Recovery Fund from any Subsequent Opioid Settlement. Except as otherwise stated in this Agreement, the terms of Section III of the 2022 State-Subdivision MOU shall govern the establishment, existence, and operation of the Recovery Council. In the event the 2022 State-Subdivision MOU is terminated or otherwise ceases to be in effect, the terms of this Section III shall govern the establishment, existence, and operation of the Recovery Council.

A Recovery Fund Council (the "Council") consisting of representatives appointed by the State and subdivisions, shall be created to direct the disbursement of recovery funds for recovery purposes on a statewide basis for the uses allowed by this MOU.

Membership: The Recovery Council shall consist of eleven (11) members, who shall serve in theirofficial capacity only.

Subdivision Members: The Recovery Council shall include at least 4 members from the plaintiff cities or counties to be selected by them.

State Members. Four (4) members shall be appointed by the State as follows:

a. The Governor shall appoint two members
b. The Speaker of the House or his designee
c. The President of the Senate or his designee

Public Members. The Attorney General shall appoint three (3) public members from among the following:

a. Individuals or family members impacted by the Opioid Crisis
b. Individuals with substance use disorder and recovery community experience,
c. Public health experts in treatment and or prevention.

The Legislature may add members to the Council for up to a maximum of fifteen (15).

Terms: The Recovery Council shall be established within ninety (90) days of the Effective Date and initial members appointed. Members may serve no more than two (2) consecutive two-

year terms, fora total of four (4) consecutive years.

Duties: The Recovery Council is primarily responsible for ensuring that the distribution of Recovery Funds complies with the terms of the MOU and the Agreement entitled "Maine School Administrative Units' Inclusion in Maine's Recovery Fund". It shall meet at least twice within each calendar year either in person or via a remote meeting method as allowed by Maine law.

Governance: The Recovery Council shall draft its own bylaws or other governing documents, which must include appropriate conflict of interest provisions, in accordance with this MOU and the following principles:

a. Authority: The Recovery Council does not have any rulemaking authority. The terms of theMOU and Agreement and any Settlement, as entered by a Court of competent jurisdiction control the authority of the Recovery Council and the Recovery Council shall not stray outside the bounds of the authority and power vested by this MOU and any Court approved Settlement.

b. Administration: The Recovery Council is responsible for accounting of all Recovery Funds.and for releasing Recovery Funds.

Transparency: The Recovery Council shall operate with all reasonable transparency and in compliance with Maine's Freedom of Access Law 1 MRS sections 401 et seq.

The Recovery Council shall develop a centralized public dashboard or other repository for publication of expenditure data from any party or Regional Council that receives Recovery Funds. The Council may require outcome related data from any entity that receives Recovery Funds. For purposes of funding the centralized dashboard, the Council shall make every effort to use existing state resources.

Collaboration: The Recovery Council shall facilitate collaboration among the State, subdivisions, Regional Councils and other stakeholders for the purposes of sharing data, outcomes, strategies and other relevant information related to abating the opioid crisis in Maine.

Decision Making: The Recovery Council shall make all decisions by consensus. In the event consensus cannot be achieved, unless otherwise required by this MOU, the Council shall make decisions by 3/5 vote of its members.

Legal Representation: The Attorney General shall provide legal counsel and administrative support to the Recovery Council. The Council may use funds to hire additional administration support if necessary.

Compensation: No member of the Recovery Council shall be compensated for their work related to the Recovery Council.

IV. THE MAINE RECOVERY FUND

A. Fund Established. The parties agree that the existing Maine Recovery Fund, as established by Section IV of the 2022 State-Subdivision MOU, shall receive payments allocated in Section II herein from any Subsequent Opioid Settlement. Except as otherwise stated in this Agreement, the terms of Section IV of the 2022 State-Subdivision MOU shall govern the establishment, existence, and operation of the Recovery Fund. In the event the 2022 State-Subdivision MOU is terminated or otherwise ceases to be in effect, the terms of this Section IV shall govern the establishment, existence, and operation of the Recovery Council.

B. The Maine Recovery Fund is established for the purposes specified in this agreement as a separate and distinct fund for accounting and budgetary reporting purposes.

C. Sources of Fund. The State Controller shall credit to the fund:

1. All money designated to the Maine Recovery Fund for abatement in this agreement from any Subsequent Opioid Settlement;

2. Money from any other source, whether public or private, designated for deposit into or credited to the fund; and

3. Interest earned or other investment income on balances in the fund.

D. Unencumbered Balances. Notwithstanding any provision to the contrary in Section IV.C of the 2022 State-Subdivision MOU, any unencumbered balance remaining at the end of any fiscal year remains part of the Maine Recovery Fund, the account within the Office of the Attorney General established pursuant to this section and may be made available for expenditure by the Recovery Council in the same manner as other money in the Fund.

E. General Fund Limitation. Notwithstanding any provision to the contrary in this section, any program, expansion of a program, expenditure or transfer authorized by the Legislature using the Maine Recovery Fund may not be transferred to the General Fund without specific legislative approval.

F. Restricted Accounts. The State Controller is authorized to establish separate accounts within the fund in order to segregate money received by the fund from any source, whether public or private, that requires as a condition of the contribution to the fund that the use of the money contributed be restricted to approved uses. Money credited to a restricted account established under this subsection may be applied only to the purposes to which the account is restricted.

G. Adjustment to Allocations. For state fiscal years beginning on or after July 1, the State Budget Officer is authorized to adjust allocations if actual revenue collections for the fiscal year are less than the approved legislative allocations. The State Budget Officer shall review the programs receiving funds from the fund and shall adjust the funding in the All Other line category to stay within available resources. These adjustments must be calculated in proportion to each account's allocation in the All Other line category in relation to the total All Other allocation for fund programs. Notwithstanding any other provision of law, the

allocation for the identified amounts may be reduced by financial order upon the recommendation of the State Budget Officer and approval of the Governor. The State Budget Officer shall report annually on the allocation adjustments made pursuant to this subsection to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters by May 15th.

H. Separate Accounts; Annual Reporting. A state agency that receives allocations from thefund, and a county, a city, and a contractor or vendor that receives funding allocated from the fund shall maintainthat money in a separate account and shall report by September 1st of each year to the Recovery Council providing a description of how those funds for the prior state fiscal year were targeted to the Approved Uses. The Attorney General shall by October 1st of each year compile the reports provided under this subsection and forward the information in a report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters. In addition to the compilation described in this subsection, the report must summarize the activity in any funds or accounts directly related to this section..

I. **Legislative Committee Review of Legislation.** Whenever a proposal in a resolve or bill beforethe Legislature, including but not limited to a budget bill, affects the fund, the Recovery Council, upon notice of the proposal from any source, may submit a request through its Chairperson to the joint standing committee of the Legislature having jurisdiction over the proposal, and to the joint standing committee of the Legislature having jurisdiction over health and human services matters, that the committee with jurisdiction over the proposal hold a public hearing and determine the level of support for the proposal among members of the committee. If there is support for the proposal among amajority of the members of the committee, the Recovery Council Chairperson may request that the committee request the joint standing committee of the Legislature having jurisdiction over health and human services matters review and evaluate the proposal as it pertains to the fund. The joint standing committee of the Legislature having jurisdiction over health and human services matters shall conduct the review and report to the committee of jurisdiction, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, and to the Recovery Council.

The Maine State-Subdivision Memorandum of Understanding and Agreement Regarding Use of Settlement Funds-2023 is signed by:

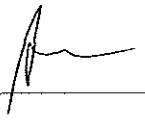
AARON M. FREY
ATTORNEY GENERAL

Brendan O'Neil
Assistant Attorney General

Date: May 2, 2023

6 State House Station
Augusta, ME 04333
207-626-8800

For the following Subdivision:



Signature

Date: 5/2/2023

Name: Shayna E. Sacks

Title: Partner

On behalf of: _____

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**").[1]

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. 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.

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

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

3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME**

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, the following[1]:

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

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

8. 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. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance

programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

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

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

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

    2. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail

or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

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

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

    1. Increase the number of prescribers using PDMPs;

    2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

    3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

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

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

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

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

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide

care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

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.

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State	County	City	Consolidated State Allocation
ME	ANDROSCOGGIN COUNTY		1.6799535986%
ME	ANDROSCOGGIN COUNTY	Lewiston city	4.3451006968%
ME	ANDROSCOGGIN COUNTY	Auburn city	2.6283332826%
ME	AROOSTOOK COUNTY		4.0537116218%
ME	CUMBERLAND COUNTY		3.5025701951%
ME	CUMBERLAND COUNTY	Portland city	7.2016026249%
ME	CUMBERLAND COUNTY	South Portland city	2.2275994495%
ME	CUMBERLAND COUNTY	SCARBOROUGH TOWN	1.8363769930%
ME	CUMBERLAND COUNTY	BRUNSWICK TOWN	1.6113929261%
ME	CUMBERLAND COUNTY	Westbrook city	1.5416150467%
ME	CUMBERLAND COUNTY	GORHAM TOWN	1.4582940317%
ME	CUMBERLAND COUNTY	FALMOUTH TOWN	1.2353278939%
ME	CUMBERLAND COUNTY	WINDHAM TOWN	0.1935482073%
ME	CUMBERLAND COUNTY	STANDISH TOWN	0.0664145731%
ME	FRANKLIN COUNTY		1.9717572454%
ME	HANCOCK COUNTY		3.8494340111%
ME	KENNEBEC COUNTY		4.9959268385%
ME	KENNEBEC COUNTY	Augusta city	3.6779545807%
ME	KENNEBEC COUNTY	Waterville city	2.8132809688%
ME	KNOX COUNTY		2.1010369789%
ME	KNOX COUNTY	Rockland city	0.6184398003%
ME	LINCOLN COUNTY		2.1621727981%
ME	OXFORD COUNTY		3.8454418782%
ME	PENOBSCOT COUNTY		6.7801027597%
ME	PENOBSCOT COUNTY	Bangor city	5.2042873123%
ME	PENOBSCOT COUNTY	ORONO TOWN	0.2094180830%
ME	PISCATAQUIS COUNTY		1.2760851978%
ME	SAGADAHOC COUNTY		1.9708146889%
ME	SOMERSET COUNTY		3.6977198467%
ME	WALDO COUNTY		2.4723925078%
ME	WASHINGTON COUNTY		2.6998574469%
ME	WASHINGTON COUNTY	Calais city	0.8369049504%
ME	YORK COUNTY		6.7950503019%
ME	YORK COUNTY	Biddeford city	2.7393997300%
ME	YORK COUNTY	Sanford city	2.6908215844%
ME	YORK COUNTY	YORK TOWN	2.1005084476%
ME	YORK COUNTY	Saco city	0.4366518238%
ME	YORK COUNTY	WELLS TOWN	0.2541311729%
ME	YORK COUNTY	KENNEBUNK TOWN	0.2185679049%

City Council

Meeting Date: April 2, 2024
Meeting Time: 6:00 pm

Agenda Item No: 8.e. 2024.43
Item Description: Approval/Opioid Use Settlement Funds refer to Policy Committee

Submitted by:

Supporting Information/Documentation:

• Opioid Use Settlement Fund Draft Ordinance

• Maine Memorandum of Understanding Regarding Opioid Settlement Funds

• Maine Opioid Settlement Payments-Estimated-by Entity 2024.3.11

• Maine Opioid Settlement Payments-Actual-by Entity 2024.3.11

Key Terms:

- Opioid Crisis: A nationwide public health emergency concerning the excessive use of and addiction to opioids, including prescription pain relievers, heroin, and synthetic opioids.
- Opioid Settlement: A series of legal agreements involving multiple states, mandating major pharmaceutical companies to pay reparations to states, counties, and municipalities with populations exceeding 10,000, due to their role in the opioid epidemic.
- Opioid Use Settlement Fund: A dedicated account proposed for the management, tracking, and reporting of revenues and expenses linked to the opioid settlement.

Executive Summary:

The City of Biddeford, like many other U.S cities, has been deeply affected by the opioid crisis. As part of the opioid settlement, the city is projected to receive approximately $1,818,254 by 2038, averaging $106,956 annually. To ensure these funds are allocated transparently and effectively, the "Opioid Use Settlement Fund Tracking and Reporting Ordinance" has been formulated.

Detailed Review:

The Opioid Use Settlement Fund Tracking and Reporting Ordinance mandates:

• The establishment of a dedicated "Opioid Use Settlement Fund" account.

• Annual reporting to the City Council on the fund's status.

• Approval of a strategic plan every two years by the City Council, detailing the goals and pre-approved operational use of these funds.

These mandates have been proposed to help guide the allocation of settlement funds towards addressing the multifaceted challenges of the opioid epidemic. This process underscores the City's dedication to transparency, accountability, and a strategic vision in managing these funds. Considering the past and present impact of the opioid epidemic on the community, it is recommended to have structured mechanisms in place to facilitate the effective channeling of settlement funds to benefit the most impacted members of our city and support recovery efforts.

Funding Source:

Opioid Use Settlement. An estimated total of $1,818,254 is projected to be received by 2038, with an average annual allocation of $106,956. These allocations are front-loaded, experiencing a significant decrease starting in 2032.

Staff Recommendation:

Neutral

SUBJECT: Revisions to the Opioid Use Settlement Fund Ordinance Based on Policy Committee Feedback

Item Description: Creation and Management of Opioid Use Settlement Fund

Supporting Information/Documentation:
- Revised Opioid Use Settlement Fund Ordinance
- May 20th Opioid Use Settlement Policy Memo
- Maine Memorandum of Understanding Regarding Opioid Settlement Funds

Key Terms:
- Opioid Use Settlement Fund: A dedicated account proposed for the management, tracking, and reporting of revenues and expenses linked to the opioid settlement.

Executive Summary:
Following the Policy Committee's meeting on May 20th, several revisions were made to the proposed Opioid Use Settlement Fund Ordinance to enhance its clarity, flexibility, and effectiveness. This memo outlines the specific changes implemented based on the Committee's feedback.

Detailed Review:

1. Explicit Date/Time of Year for Annual Financial Review and Strategic Planning Process/Approval (*Article IV & V*):

Change:
The ordinance now mandates that the annual financial report on the Opioid Use Settlement Fund shall be submitted to the City Council by the first City Council meeting in September. Furthermore, the ordinance now clarifies that the strategic plan for the operational use of the Opioid Use Settlement Fund must be adopted by the second City Council meeting of November every two years.

Rationale:
This change ensures a consistent and predictable timeline for the financial review and strategic planning process providing clear deadlines for action. This date aligns with the City's required reporting to the state under the Maine State-Subdivision Memorandum of Understanding, which mandates a report by September 1st each year to the Recovery Council detailing the use of funds for Approved Uses.

2. Flexibility in Developing the Strategic Plan (*Article IV*):

Change:
The ordinance has been revised to allow the strategic plan to be developed by city staff and/or a designated committee. The City Council retains the authority

to approve the plan but is no longer required to be directly involved in its development.

Rationale:
This adjustment provides greater flexibility in the strategic planning process, enabling the City to leverage the expertise of staff and committees while streamlining the Council's role. This allows for a more efficient process without compromising the Council's oversight and approval responsibilities.

3. Explicit Guidelines on the Approved and Banned Uses of the Funds (*Article III*):

Change:
The ordinance now includes explicit language that defines:

- **Approved Uses:** Funds must be used solely for opioid use disorder prevention, harm reduction, treatment, and recovery.
- **Banned Uses:** The ordinance explicitly prohibits the use of these funds to supplant any existing budgeted expenditures. The funds must not be used to offset or replace funding for programs or services that are currently financed through other sources.

Rationale:
These clarifications ensure that the funds are used to enhance and supplement existing resources, rather than replacing them, thereby maximizing their impact on addressing the opioid crisis. The focus on prevention, harm reduction, treatment, and recovery aligns the ordinance with the intended purposes of the settlement funds.

Conclusion:

The revisions to the Opioid Use Settlement Fund Ordinance incorporate the changes requested by the Policy Committee at their May 20th meeting. These changes attempt to align with the Committee's direction and strengthen the ordinance's ability to effectively achieve its intended purpose.

Funding Source:
Opioid Settlement. Expected total of $1,818,549 by 2038 with an annual average allocation of $106,956.

Staff Recommendation:

Policy Committee

Meeting Date:	August 26, 2024
Meeting Time:	6:00 PM
Agenda Item No:	5.d
Item Description:	Transfer Station Fees
Submitted By:	Jeff Demers Public Works Director

Supporting Information/Documentation:

Transfer-street opening proposed fee's, Transfer sticker

Key Terms:

Executive Summary:

The new fees are for the City of Biddefords transfer station and public works street openings.

Detailed Review:

The City manager requested department heads look at all fees being collected within the departments they are responsible for overseeing. Public works looked at all the surrounding public works/solid waste departments and the fees being charged to date. Attached to the spreadsheet are the rates today and the proposed new transfer station rates that are comparable with the surrounding communities. The Recycling and waste management Commission looked into this at their last two meetings and voted 6-0 to move this forward to policy. These adjusted rates will help keep other residents from surrounding communities from dumping in Biddeford.

The staff is also requesting that the public works department be allowed to adopt a sticker policy. This policy will be required to dump any items at the transfer station as of October 1st, 2024 “All vehicles disposing of any waste at the Transfer Station shall be required to have a current City of Biddeford Transfer Station Sticker attached to the vehicle. Failure to have the sticker attached to your vehicle will result in the inability to dispose of any acceptable waste at the Transfer Station.”

Why is this being requested today? The drive in policy and ID has been very tough for city staff to enforce and very time-consuming and aggravating for the residents at times. However, over the past couple of years, the City has seen an increase in nonresident vehicles trying and utilizing the Biddeford Transfer Station. As costs in other communities increase, nonresidents have at times been trying to dispose of their waste at the city of Biddefords Transfer Station, taking advantage of the City's lower cost and free recycling. The usage of the City's Transfer Station by non-residents is costing residents more money to fund the Transfer Station. In order to ensure that only City of Biddeford residents dispose of their waste at the Transfer Station and keep our costs as low as possible, Public works is requesting the sticker policy. If this policy is adopted by Policy and Council.

Public works staff will hand out stickers daily for the next few months to all residents after confirming they are a legal resident of Biddeford. Starting early next year, the City clerk and Public works director have worked on a plan to give them out as people register their vehicles. The first two stickers will be free. Three or more, there would be a $5 charge at the recycling center.
The Recycling and waste management Commission also looked into this and voted 6-0 to move this forward to policy.

The staff understands that many people do not like to have a sticker on their vehicle. Unfortunately, this is a better method than making residents show proof of residency multiple times a year to public works staff and help effectively control who utilizes the Transfer Station.

Funding Source:

$1800 requested from the solid waste 21164-60502 Printing/copying with a balance of approximately $4800

Staff Recommendation:

Public works recommends the policy committee to send this forward to the city council for acceptance.

TRANSFER STATION FEES

City/Town	Demo	AC/Fridge	Tires	Couch	TV/Comp	Brush/Grass	Metal	Mattress/Box
Scarboruogh		USE			Riverside			
Wells	$.08 LBS	$10	W/R $10	$5 $15	> 30" $5 < 30" $10	$.05 per lbs	Per Item	$10
Sanford	$25 per YD	$20	W/R $10	$5 $15	> 30"$5 < 30" $10	$5 per yd	Free	$15
Cape Elizabeth		$15 Doors Removed	$5 any size		> 24" $5 < 24" $10	1 yard free over $20		$10
North Berwick	Per Item	$15 doors removed	> 15" $3 < 15" $5	$10	> 24" $5 < 24" $10	Don't take	Per Item	$10
Lyman	Per Item	$15	>16" $4 <16" $10		> 19"$10 < 19" $20	??	Per Item	$20 $20
Waterboro	$25 per YD	$15	car $15 trk $15	$10	> 21" $5 < 21" $7	$25 per yd Grass $6 yd	Free	$15
Alfred	$25 per yd	$10	car $3 trk $10		Free		??	$5
Riverside	$140 per ton	$25	$10 no rim $15 on rim		$10	Grss $30 ton brsh $58 ton	$5 per ton	$40,$45 $50
South Portland	$20 per yd	$25	$10 w/o $15 w/r	$20	Not Accepted	Res free Con $10 yd	Free	?
Saco	Res $15 yd Con $30	$15	car $5 trk $10	$15	cpu $3 Tv's $5	Res $6 yd Com $10 yd	Free	?

TRANSFER STATION FEES

Biddeford	1 yd Free $20 Yd aftr	$20	4 free per Cars $5 Trk $8	Free	Free	Res free Con $10 yd	Free	Free
New Price:	$5.00 1st yard No Yd (Free) $20 Yd after	No Change	$3.00 per car tire $8.00 Truck tire $5.00 xtra on rim No More (Free)	$ 10.00	cpu $5.00 Tv $5.00	No Change	No Change	$ 15.00

Estimated July 1, 2023 - May,15 2024 New fee Revenue			Tires - 1350 x $5.00 $6750	Couch - 92 x $10.00 $920	Tv - 661 X $ 5.00 $3305 cpu - 318 x $ 5.00 $1590			Mattress-80 x15.00 $1200
							Total = $13,765 New Revenue	
Street openings	2024	16						
	2023	71						
	2022	93						
Total		180						
Old fee	$35	$6,300						
New fee	$425	$76,500						

City/Town	Street Opening Fee		
Biddeford	$ 30.00		
Lewiston	$ 500.00		
Portland	$ 450.00		
S.Portland	$ 507.00		
Scarbourough	$ 80.00		
Brunswick		11/1 - 3/15 = $550.00	3/16 - 10/31 = $150.00
Saco	$ 30.00		
Sanford	$ 25.00		
Wells	$ 50.00		
Cape Elizabeth	$ 100.00		

New street opening fee with inspection = $425.00

1.5" x 2" Mirror Decals - Design MD8

Select Material and Order Quantity

Select a material and quantity for your permit. For material specs, click on ? buttons below. You may take advantage of our **Quantity Discount Program**. This means that if you order more, you'll get better price.

1500
.26

Select Material ?

Price per Label
(10 Labels/Pack)

Compare Prices at Different Quantities
(Prices are per Label
and rounded to nearest hundredth)

		50	100	150	250	500	1000	1500
Non-Reflective (Traditional)								more »
○ Vinyl Labels	?	$2.89	$1.48	$1.16	77.6¢	43.2¢	27.2¢	26.2¢

Material Features:
› 3 mil thick vinyl has a protective plastic
› Designed for textured surfaces, such as a
› Once adhesive is cured, labels cannot be
More Material Details

Mouse over icons for more details:

Minimum order quantity is 5 Packs. There are 10 Labels per Pack. Subsequent quantity should be a multiple of 1 Pack.

Quantity - 5 + Packs Total: 50 Labels

Price / Label **$2.888**

Total Cost **$144.40**

○ Holographic (Permanent)	?	$3.37	$1.82	$1.47	82.5¢	57.8¢	49.2¢	40.8¢
○ Metallized Mylar (Permanent)	?	$3.47	$1.86	$1.46	$1.04	56.6¢	33.5¢	31.1¢
Reflective (High Security)		50	100	150	250	500	1000	1500
○ Reflective (Permanent)	?	$2.63	$1.37	$1.05	75.2¢	41.5¢	27.4¢	25.8¢

Back Next Step