LEGISLATIVE SUMMARY SHEET
Tracking No. 0260-22

DATE: December 15, 2022

TITLE OF RESOLUTION: AN ACT RELATING TO BUDGET AND FINANCE, HEALTH, EDUCATION AND HUMAN SERVICES, AND NAABIK'ÍYÁTI' COMMITTEES AND THE NAVAJO NATION COUNCIL; ESTABLISHING THE "OPIOID LITIGATION SETTLEMENT FUND"; DIRECTING THAT MONIES RECEIVED FROM *IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION, ON AUGUST 5, 2015*, MDL NO. 2804; CASE NO. 17-md-02804 AND RELATED ACTIONS BE DEPOSITED IN THE OPIOID LITIGATION SETTLEMENT FUND; REIMBURSING THE FIXED COST LITIGATION ACCOUNT FOR LITIGATION COSTS

PURPOSE: This resolution, if approved, establishes the Opioid Litigation Settlement Fund to house the proceeds of the Navajo Nation's litigation against Opioid manufacturers and distributors. The proceeds can only be expended for opioid and substance use recovery and abatement and will be allocated through annual or multi-year expenditure plans recommended by the Executive Director of the Department of Health and approved by the Budget and Finance Committee and the Health Education and Human Services Committee.

This written summary does not address recommended amendments as may be provided by the standing committee. The Office of Legislative Counsel requests each Council Delegate to review the proposed resolution in detail.

5-DAY BILL HOLD PERIOD: J Johnson
Website Posting Time/Date:
Posting End Date: 12-20-22
Eligible for Action: 12-21-22

Budget & Finance Committee
Thence
Health Education & Human Services Committee
Thence
Naabik'íyáti' Committee
Thence
Navajo Nation Council

PROPOSED NAVAJO NATION COUNCIL RESOLUTION
24th NAVAJO NATION COUNCIL – Fourth Year, 2022
INTRODUCED BY

_____
(Prime Sponsor)

TRACKING NO. 0260-22

AN ACT

RELATING TO BUDGET AND FINANCE, HEALTH, EDUCATION AND HUMAN SERVICES, AND NAABIK'ÍYÁTI' COMMITTEES AND THE NAVAJO NATION COUNCIL; ESTABLISHING THE "OPIOID LITIGATION SETTLEMENT FUND"; DIRECTING THAT MONIES RECEIVED FROM *IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION, ON AUGUST 5, 2015*, MDL NO. 2804; CASE NO. 17-md-02804 AND RELATED ACTIONS BE DEPOSITED IN THE OPIOID LITIGATION SETTLEMENT FUND; REIMBURSING THE FIXED COST LITIGATION ACCOUNT FOR LITIGATION COSTS

BE IT ENACTED:

SECTION ONE. AUTHORITY

A. The Navajo Nation Council is the governing body of the Navajo Nation and empowered to enact positive law of the Navajo Nation. 2 N.N.C. §§ 102 (A) and 164 (A).

B. The Naabik'iyati' Committee of the Navajo Nation Council is empowered to review all proposed legislation which requires final action by the Navajo Nation Council. 2 N.N.C. §164 (A)(9).

C. The Budget and Finance Committee of the Navajo Nation Council is empowered to review and recommend to the Navajo Nation Council the budgeting, appropriation, investment, and management of all funds. 2 N.N.C. § 301 (B)(2).

D. The Health, Education and Human Services Committee of the Navajo Nation Council is empowered to review and recommend resolutions relating to social services, health, environmental health, education, veterans and veterans' services, employment and labor. 2 N.N.C. §§ 164(A)(1), 400(A) and 401(b)(6)(a).

E. The Navajo Department of Justice is responsible for providing legal services to the Navajo Nation government. The Attorney General, as the Chief Legal Officer, has charge of the Department of Justice and of all legal matters in which the Navajo Nation government has an interest. This includes the authority to settle any action or claim by the Navajo Nation. Before concluding any such settlement, the Attorney General shall consult with the relevant branch and division or department. 2 N.N.C. §§ 1962, 1964(A) & (F).

SECTION TWO. FINDINGS

A. The Native American population has suffered some of the worst consequences of the opioid epidemic of *any* population in the United States. American Indians have suffered the highest per capita rate of opioid overdoses according to the National Congress of American Indians Policy Research Center, Reflecting on a Crisis Curbing Opioid Abuse in Communities (Oct. 2016).

B. Tribal Nations have had to spend considerable tribal funds to cover the costs of the opioid crisis, including increased costs for health care, social services, child welfare, court, law enforcement, corrections and other government services that Tribes provide to their citizens.

C. The burden of paying these increased costs has diverted scarce tribal funds from other needs and has imposed severe financial burdens on Tribal Nations, which will continue to bear significant costs related to abatement of the opioid addiction problem in our communities.

D. The horrific consequences of the opioid epidemic have struck the Navajo Nation as hard as they have struck other Tribal Nations and communities. In response, the Navajo Department of Justice sued opioid manufacturers and distributors on behalf of the Navajo Nation in 2015. The federal District Court subsequently consolidated tribal cases, including the Navajo Nation's suit, against opioid manufacturers, distributors, and certain pharmacies into one legal action entitled *In Re: National Prescription Opiate Litigation*, MDL NO. 2804; CASE NO. 17-md-02804.

E. The federal District Court appointed a Plaintiff's Tribal Leadership Committee ("TLC") to coordinate the tribal litigation and to advocate for all Tribes in *In Re: National Prescription Opiate Litigation* and in any settlement negotiations. The TLC reached a settlement with numerous opioid manufacturers and distributors under which the Navajo Nation will receive formula-based settlement proceeds. The final amount of the settlement proceeds has not yet been determined. *See* **Exhibits A - C.**

F. Any proceeds from *In Re: National Prescription Opiate Litigation* can only be expended to support treatment of Opioid Use Disorder and any co-occurring Substance Use Disorder or Mental Health conditions through evidence-based or evidence-informed programs or strategies. The TLC has provided a non-exhaustive list of eligible uses attached as **Exhibit D.**

G. The Navajo Nation Council has determined that the most efficient way to ensure that its litigation and settlement awards from current and future opioid litigations are used only to support treatment of Opioid Use Disorder and any co-occurring Substance Use Disorder or Mental Health conditions is to segregate the awards into an Opioids Litigation Settlement Fund.

SECTION THREE. ESTABLISHING THE OPIOID LITIGATION SETTLEMENT FUND

The Navajo Nation hereby amends Title 12 of the Navajo Nation Code and establishes the "Opioid Litigation Settlement Fund" and approves its enabling legislation as follows:

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TITLE 12. FISCAL MATTERS

CHAPTER 29. OPIOID LITIGATION SETTLEMENT FUND

§ 2901. Establishment

There is established the "Opioid Litigation Settlement Fund", hereinafter referred to as "Fund":

A. The Navajo Nation Council hereby designates that any and all net proceeds and earnings awarded to the Navajo Nation by or through litigation arising from the impact of opioid use and abuse, including the proceeds from *In Re: National Prescription Opiate Litigation,* MDL NO. 2804; CASE NO. 17-md-02804, shall be deposited into the Fund after the Fixed Cost Litigation Account has been reimbursed for the actual costs of said litigation(s), as calculated and attested to by the Attorney General of the Navajo Nation.

B. The Navajo Nation Council may make additional appropriations to the Fund from any other sources of revenue that become available to the Navajo Nation.

D. Any money deposited in or appropriated to the Fund, regardless of source, including earnings thereon, shall be used only as provided in this Chapter.

E. The Fund shall be a continuing account and shall not lapse on an annual basis pursuant to 12 N.N.C. § 820(N).

§ 2902. Purpose

A. The purpose(s) of this Fund is to provide opioid and co-occurring substance use and mental health treatment, prevention and abatement efforts, including both services and infrastructure to support such services.

B. Expenditures from the Fund shall not be subject to or limited by 12 N.N.C. § 810(F) of the Appropriations Act, 12 N.N.C. § 1310(F) of the Bond Financing Act, or the

Capital Improvement Project Guidelines, Policies, and Procedures approved through TCDCJY-77-99.

§ 2903. Investment of the Fund

All monies deposited in the Fund shall be subject to the Master Investment Policies, as amended, and invested as soon as practical in accordance with the degree of care exercised by reasonable and prudent managers of investments intended to produce maximum growth of the investments with a high degree of safety necessary to fulfill the purposes and objectives of the Fund.

§ 2904. Definition of Fund Principal and Income

A. "Fund Principal" shall consist of all deposits made to the Fund pursuant to Section §2901 of this Chapter.

B. "Fund Income" shall consist of all earnings (interest, dividends, etc.) generated and realized through the investment of the Fund Principal. Realized Fund Income shall be added to the Fund Principal after Fund management and administration expenses, as set forth in this Chapter, have been deducted.

§ 2905. Expenditure of the Fund

A. The Fund Principal and Income shall be expended upon recommendation by the Executive Director of the Navajo Nation Division of Health through an annual or multi-year expenditure plan approved by the Budget and Finance Committee and then by the Health, Education and Human Services Committee.

B. Notwithstanding § 2905(A) of this Chapter, the construction of a stand-alone 12 Step Meeting House in each Navajo Nation Agency, i.e., Chinle Agency, Eastern Agency, Ft. Defiance Agency, Northern Agency, and Western Agency, including furnishings cost and operations and maintenance costs, shall be funded prior to the funding of other opioid and co-occurring substance use and mental health treatment, prevention and abatement efforts.

C. Any changes or modifications to an approved expenditure plan shall be approved by the Budget and Finance Committee and then by the Health, Education and Human Services Committee upon the recommendation of the Division Director of the Navajo Nation Division of Health.

D. Any Fund amounts, whether Fund Principal or Fund Income, not included in an expenditure plan, shall remain invested as set forth herein.

§ 2906. Annual Audit

The Fund shall be audited annually by independent auditors and within 120 days of the end of each fiscal year, an audit report shall be distributed to the members of the Navajo Nation Council. The audit report shall be written in easily understandable language.

§ 2907. Fund Management Expenses

All expenses associated directly with the administration and management of the Fund shall be paid from the Fund Income. Such expenses shall include investment advisory and management fees, audit costs, and other related expenses, all pursuant to duly approved contracts for such services.

§ 2908. Amendments

Any section(s) of this Chapter may be amended by a two-thirds (2/3) majority vote of the full membership of the Navajo Nation Council and approval of the President of the Navajo Nation.

§ 2908. Termination

The Fund shall expire and terminate when all Fund Principal and Fund Income have been expended.

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SECTION FOUR. APPROVING REIBURSEMENT OF LITIGATION COSTS

A. The Navajo Nation Department of Justice shall be reimbursed for the actual litigation costs and expenses expended in *In Re: National Prescription Opiate Litigation,* MDL NO. 2804; CASE NO. 17-md-02804 and any related and/or future causes of action, including but not limited to any and all settlements and awards stemming from such litigation.

B. All monies awarded to the Department of Justice under this Act shall be deposited into the Fixed Cost Litigation Account prior to any monies being deposited into the Opioid Litigation Settlement Fund.

SECTION FIVE. EFFECTIVE DATE

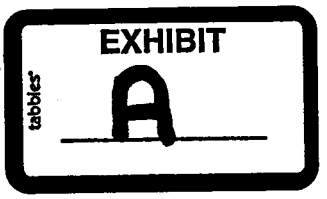
This Act is effective upon its approval pursuant to 2 N.N.C. 221(B).

SECTION SIX. CODIFICATION

The provisions of this Act which amend or adopt new sections of the Navajo Nation Code shall be codified by the Office of Legislative Counsel. The Office of Legislative Counsel shall incorporate such amended provisions in the next codification of the Navajo Nation Code.

SECTION SEVEN. SAVINGS CLAUSE

Should any provision(s) of this Act be determined invalid by the Navajo Nation Supreme Court or the District Courts of the Navajo Nation, without appeal to the Navajo Nation Supreme Court, the remainder of the Act shall remain the law of the Navajo Nation.



IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	**MDL No. 2804**
	Case No. 17-md-02804
THIS DOCUMENT RELATES TO: *All MDL Tribal Cases*	**Judge Dan Aaron Polster**

PLAINTIFFS' TRIBAL LEADERSHIP COMMITTEE'S
STATEMENT REGARDING PARTIAL SETTLEMENTS

The undersigned counsel, in their capacity as members of the Plaintiffs' Tribal Leadership Committee (TLC), respectfully notify the Court that they have reached settlements in principle to resolve Native American/Alaska Native Tribal claims against Janssen Pharmaceuticals, Inc., Janssen Pharmaceutica, Inc. N/K/A Janssen Pharmaceuticals, Inc., Johnson & Johnson, Ortho-McNeil-Janssen Pharmaceuticals, Inc., N/K/A Janssen Pharmaceuticals, Inc. ("Janssen"), and with AmerisourceBergen Corp., McKesson Corp., and Cardinal Health, Inc. ("Distributors") (collectively "Settling Defendants"). All federally recognized Tribes are eligible to participate in both settlements.

The TLC and Janssen agreed to resolve the Tribal claims for $150,000,000, payable over two years.

The TLC and the Distributors resolved the Tribal claims for $439,964,500, payable over seven years. This amount does not include the $75,035,500 settlement of the Cherokee Nation's bellwether litigation previously agreed to by the Cherokee Nation and the Distributors.

The TLC and the Settling Defendants entered into settlement Term Sheets summarizing their agreements and are in the process of drafting definitive settlement agreements. All federally recognized Tribes will receive notice of how they may participate in both settlements. All federally recognized Tribes will be eligible to participate in both settlements regardless of whether the Tribe has previously filed suit against the Settling Defendants.

In support of this Statement, the TLC reports:

1. The Native American population has suffered some of the worst consequences of the opioid epidemic of *any* population in the United States. Indeed, American Indians have suffered the *highest* per capita rate of opioid overdoses.[1] "American Indians and Alaska Natives had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999-2015 compared to other racial and ethnic groups."[2] For this reason, Tribal governments across the United States have had to spend considerable tribal funds to cover the costs of the opioid crisis, including increased costs for health care, social services, child welfare, law enforcement and other government services that Tribes provide to

[1] National Congress of American Indians Policy Research Center, *Reflecting on a Crisis Curbing Opioid Abuse in Communities* (Oct. 2016), http://www.ncai.org/policy-research-center/research-data/prc-publications/Opioid_Brief.pdf.

[2] Statement by RADM Michael E. Toedt, MD, FAAFP, "Opioids in Indian Country: Beyond the Crisis to Healing the Community," March 14, 2018 Hearing Before the U.S. Senate Committee on Indian Affairs, (https://www.indian.senate.gov/sites/default/files/upload/HHS%20IHS%20testimony%20Opioids%20Indian%20Country%20SCIA%203-14-18%20revised.pdf.), citing to Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, "Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas – United States," Oct. 20, 2017 (https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf).

their citizens. The burden of paying these increased costs has diverted scarce tribal funds from other needs and has imposed severe financial burdens on the Tribal Plaintiffs, which will continue to bear significant costs related to abatement of the opioid addiction problem in their communities.

2. The Court appointed the members of the TLC. The TLC serves the interests of the Tribal Plaintiffs that filed suit against the Settling Defendants and others in this consolidated MDL proceeding. In total there are 418 federally recognized Native American Tribal governments and 17 inter-tribal organizations with litigation pending before the Court against the opioid manufacturers, distributors, and certain pharmacies, all of whom these Tribal Plaintiffs maintain are responsible for the opioid crisis. This represents over 70% of the 574 federally recognized Tribes in the United States and an estimated 85% of all Tribal citizens.

3. The Court designated the TLC to coordinate the interests of these Tribal Plaintiffs, including with regard to global resolution of opioid-related claims against the Defendants, including the Settling Defendants.

4. The TLC has been engaged in parallel but separate settlement negotiations with Janssen and the Distributors. Special Master David Cohen, who this Court appointed on March 9, 2021 to address Tribal issues, *see* Doc. 3646, consensually and successfully mediated the proposed agreement between the TLC and Janssen. Former U.S. District Judge Layn Phillips consensually and successfully mediated the agreement between the TLC and the Distributors.

5. The TLC and the Settling Defendants executed Term Sheets reflecting settlement terms the parties will now incorporate into settlement agreements that will be presented to all federally recognized Tribes which may then decide whether to participate.

Respectfully submitted,

Plaintiffs' Tribal Leadership Committee

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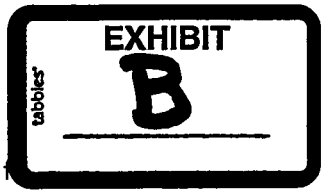
CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 1st day of February, 2022, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF System. Copies will be served upon counsel of record by, and may be obtained through, the Court CM/ECF Systems.

s/ Tara D. Sutton

Tara D. Sutton



The Distributors Tribal Opioid Settlement

A nationwide settlement has been reached to resolve all Opioids litigation brought by f recognized Tribes against the three largest pharmaceutical distributors in the United States: McKesson, Cardinal Health, and AmerisourceBergen (the "Distributors"). This settlement will provide substantial funds to participating Tribes for abatement of the opioid epidemic in Indian country.

If the proposed settlement is agreed to and adopted by Tribes nationwide:

- The Distributors will pay up to $515 million to participating federally recognized Tribes over the next six and a half years. (Of this amount, $75,035,500 has been set aside for the Cherokee Nation, which reached a separate settlement with the Distributors to resolve its bellwether litigation against them. A "bellwether" case is one that goes first and helps identify a case's strengths and weaknesses to help the parties come to a settlement for other victims.)
- The settlement is open to all 574 federally recognized Tribes, whether or not a Tribe has filed litigation against the Distributors.
- The Court overseeing the national opioids litigation appointed David Cohen and retired federal Judge Layn Phillips to set the procedures to determine the allocation of the settlement funds among the Tribes and to jointly determine that final inter-tribal allocation. When Mr. Cohen and Judge Phillips set the procedures, they will be posted here. You will have the right to comment on the allocation and suggest any changes.
- David Cohen and Judge Phillips will start with the Purdue Allocation and invite all Tribes and Alaska and California tribal health organizations to comment on whether and how that allocation should be modified for allocating the settlement money.
- The settlement will become effective 60 days after: (i) at least 95% of the litigating Tribes (as measured by their allocable shares of the settlement) agree to the settlement, and (ii) at least 14 of the 17 non-litigating Tribes with populations exceeding 5,000 tribal members agree to the settlement.
- A total of 15% of the settlement funds will be set aside to pay attorney fees. The balance of 85% of the funds that will be paid to participating Tribes must be used for abatement of the opioid epidemic in tribal communities, pursuant to a broadly defined list of approved abatement programs, activities and services, with special deference for tribal governments to decide which culturally appropriate or traditional healing practices are best suited to their communities. You may find the approved programs and uses by clicking here.
- In order to participate, a Tribe must sign and submit a Tribal Participation Form through a secure portal that may be accessed through this website.

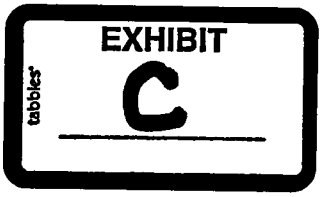
Law firms and unrepresented Tribes may submit Participation Forms quickly and easily using the secure online portal by selecting Portal Log In at the top of this screen. The Portal Log In page provides instructions for creating access credentials if you have not previously received access credentials.

In addition to the secure online portal, you may submit a Participation Form by:

- **Emailing** the signed form to nato@browngreer.com
- **Faxing** the signed form to (804) 521-7299, ATTN: Tribal Opioid Settlements
- **Mailing** the signed form to:

BrownGreer PLC
ATTN: Tribal Opioid Settlements
250 Rocketts Way
Richmond, VA 23231

MORE INFORMATION ABOUT THE DISTRIBUTORS SETTLEMENT CAN BE FOUND IN THE "FREQUENTLY ASKED QUESTIONS" (FAQ) DOCUMENT BY CLICKING HERE.



Frequently Asked Questions About the Settlements of Tribal Opioid Claims Against Janssen/Johnson & Johnson and the Three Major Opioid Distributors

February 2022

On February 1, 2022, the court-appointed Tribal Leadership Committee (TLC) announced comprehensive settlements of opioid claims asserted in cases filed by federally recognized tribes against Janssen/Johnson & Johnson (J&J) and against the three major distributors of opioid pharmaceuticals—McKesson, Amerisource Bergen and Cardinal Health.

This FAQ answers key questions about both settlements:

Q. How much money will tribes receive from the Distributor settlement?

A. The overall settlement between the distributors and all federally recognized tribes is for a total amount of up to **$515,000,000**, depending on how many tribes participate in the settlement. Of this amount, $75,035,000 was, by separate agreement with the distributors last summer, reserved for payment to the Cherokee Nation in order to resolve the Nation's active litigation against the distributors in a tribal bellwether case. The balance of up to $439,964,500 will be paid to the other federally recognized tribes who agree to participate in the settlement.

Q. How much money will tribes receive from the J&J settlement?

A. In a separate settlement between all federally recognized tribes and J&J, the company will pay up to **$150,000,000**, again depending on participation by tribes.

The settlements together total **$655,000,000** to be paid to the tribes by the distributors and J&J.

Q. Over what period of time will the Distributor's settlement money be paid?

A. The settlement funds from the distributors will be paid over a period of six and a half years, in seven equal installments of $62,852,071 each. The first payment will be made within 30 days of the "effective date," and additional payments will be made on an annual basis starting July 1, 2022.

The "effective date" is 60 days after the date on which at least 95% of all "litigating" tribes (those tribes that have filed lawsuits against the distributors) have agreed to participate in the settlement and at least 14 "non-litigating" tribes with populations exceeding 5,000 tribal

members have also agreed to participate. (For purposes of determining whether the 95% participation level for "litigating" tribes is reached, each tribe's allocation share (see below) will be used.)

Q. Over what period of time will the J&J settlement money be paid?

The settlement funds from J&J will be paid in two equal payments of $75,000,000, with the first payment to be made within 30 days of the "effective date."

For purposes of the J&J settlement, the "effective date" is the date on which at least 95% of all "litigating" tribes (those tribes that have filed lawsuits against J&J) have agreed to participate in the settlement. (There is no threshold requirement in the J&J settlement for participation by "non-litigating" tribes.)

Q. Is my tribe eligible to participate in the settlements and receive a share of the settlement funds?

A. ***ALL* 574 federally recognized tribes** are eligible to participate in the settlements and receive a share of the settlement funds. In addition, Tribal Organizations that are Co-Signers of the Alaska Tribal Health Compact are eligible to participate to receive a portion of their member tribes' allocations.

Q. Can my tribe or Alaska tribal health organization participate in the settlement if we did not file a lawsuit against these defendants?

A. Yes. Every federally recognized tribe and Alaska tribal health organization may participate in the settlement regardless of whether it previously filed a lawsuit against these defendants.

Q. What does my tribe have to do to participate in the settlements and receive its share of the settlement funds?

A. Any tribe that wishes to participate in the settlement must sign a Participation Agreement in which the tribe agrees to the terms of the settlement, agrees to dismiss any lawsuit the tribe has filed against these defendants (if the tribe has filed a lawsuit), and agrees to release all opioid-related claims that the tribe may have against these defendants. Tribes that are represented by counsel will be able to get Participation Agreement forms from their counsel. Other tribes will be able to obtain these forms from the Directors of the tribal settlement accounts (see below) who have been appointed by the court to implement and administer the settlements.

Q. Is there a deadline to participate in the settlement?

Because the "effective date" for the settlements depends on participation by tribes reaching certain threshold levels, the sooner those participation levels are reached, the sooner the settlements will go into effect and the settlement funds will start flowing to participating tribes. Non-litigating tribes will lose their right to participate in the J&J settlement if they do not file Participation Agreements within three years after the "effective date." They will lose their right to participate in the distributor settlement if they do not file Participation Agreements within four years after the "effective date."

Q. How is my tribe's share of the settlement funds determined?

A. The Tribal Leadership Committee developed a proposed inter-tribal allocation matrix that uses a variety of metrics to allocate settlement funds among all tribes. The metrics consider the severity of harms caused by the opioid epidemic throughout Indian country. The allocation matrix is built around six data points: MMEs (morphine milligram equivalents) imputed to each tribe; drug and prescription opioid overdose rates imputed to each tribe; Indian Health Service (IHS) user population for each tribe; citizenship population for each tribe; relative poverty rates imputed to each tribe; and relative cost-of-living imputed to each tribe.

The bankruptcy court in New York that is supervising the Purdue Pharma bankruptcy adopted this allocation matrix as a fair means for allocating to each tribe its share of Purdue assets that will be paid to tribes in that bankruptcy proceeding. This same proposed matrix will be used as a starting point for the J&J and Distributor settlements, subject to the final allocation process described below.

Q. What if I disagree with the allocation that my tribe is given?

A. Every tribe has the right to meaningfully participate in the final allocation process and a right to be heard prior to entry of the final allocation order. Judge Daniel Polster of the federal district court in the Northern District of Ohio, who is supervising the nationwide multi-district opioid litigation, has appointed Special Master David R. Cohen and former federal judge Layn Phillips to receive information from any participating tribe that believes its allocation share should be changed. If, for instance, the allocation formula uses an incorrect population number for that tribe, or if a tribe believes that there are special circumstances that should be taken into account in determining the allocation for that tribe, there will be an opportunity to present any such information to Special Master Cohen and Judge Phillips, who will have the authority to modify the allocation matrix if they decide it is appropriate to do so.

Q. If my tribe participates in the settlement, will we have to pay attorney fees out of our recovery?

A. No. Under the terms of the settlement, 15% of the total recovery from the distributors will be set aside for attorney fees. For the J&J settlement, 14% will be set aside for fees. The balance of the funds will be distributed to participating tribes pursuant to the allocation matrix and none of that money can be used for paying attorney fees. Attorneys working on the opioid litigation who receive compensation from the fee pots set aside for each settlement are agreeing not to seek further compensation from their tribal clients.

Q. What happens to the settlement money that is allocated to tribes that decide <u>not</u> to participate in the settlements?

A. In both settlements, if a "litigating" tribe decides not to participate in either or both settlements, its allocated share of the settlement funds in that case will be kept by the defendants.

In the J&J settlement, a "non-litigating" tribe has a period of three years after the "effective date" to decide whether to participate in the settlement. If it does not sign a Participation Agreement within that three-year period, its share of the settlement funds will be redistributed to the participating tribes based on the allocation.

In the distributor settlement, the answer is more complicated: "non-litigating" tribes have a period of four years in which to decide whether to participate in the settlement. If 67% of the "non-litigating" tribes <u>do</u> participate, then the share of any other "non-litigating" tribe that decides <u>not</u> to participate will be redistributed to all the participating tribes, up to a cap of $20 million. Any funds allocated to "non-litigating" non-participating tribes over the $20 million cap will be retained by the defendants. And if the 67% threshold for participation by "non-litigating" tribes is not reached, then all of the funds allocated to the "non-litigating" non-participating tribes will be retained by the defendants.

Q. Are there restrictions on what my tribe can do with the settlement funds?

A. Yes. Money received by each tribe from the settlements must be spent for tribal programs, services and activities to address the opioid crisis in that tribe's community. The authorized "abatement" activities are very broadly defined.

Each participating tribe will receive a lengthy memorandum listing programs, services and activities that qualify as abatement spending by state and local governments pursuant to their separate settlements with the same defendants. The same broad list of abatement programs and services will also apply to tribes. But in addition, tribes will also be able to spend settlement funds for culturally appropriate and traditional healing programs and activities, wellness courts and other tribal-specific programs and services that, in the judgment of a tribe, will promote healing, recovery and abatement in that tribe's community.

Q. How will the settlement funds be administered and distributed?

A. Judge Polster has appointed three highly qualified and well-respected Native American individuals to act as Directors of the trust accounts where the settlement funds are held. In that role, they will be responsible for reaching out to tribes to encourage participation in the settlement, for supervising the distribution of settlement funds to all participating tribes, and for providing information and oversight about appropriate abatement spending and other requirements.

Kevin Washburn is the dean of the law school at the University of Iowa and a former Assistant Secretary of Indian Affairs. Mary Smith is the former director of the Indian Health Service. And Kathy Hannan is a former partner at the accounting firm of KPMG and chairman of the board of the National Museum of the American Indian. They will work jointly to implement the settlement in coordination with Special Master David R. Cohen who will serve as administrator of the tribal trust accounts.

Q. How will more information on the settlements be made available?

A. Settlement documents, information, and updates will be posted on a public settlement website, https://nationalopioidsettlement.com/. The website will provide current information on an ongoing basis as the settlement implementation progresses.

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.

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. 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.

Schedule D
Tribal Abatement Strategies

The following is a non-exhaustive, illustrative list of culturally appropriate activities, practices, teachings or ceremonies that may, in the judgment of the Tribes, be aimed at or supportive of remediation and abatement of the opioid crisis within a tribal community.

Each of the 574 federally recognized Tribes in the United States has its own cultures, histories and traditions. Each Tribe is best suited to determine the most effective abatement strategies for the specific community it serves. The following list provides select examples of tribal abatement strategies and is not intended to limit the remediation and abatement activities for which any Tribe or tribal organization may utilize its share of Abatement Funds.

1. Traditional Activities Associated with Cultural Identity and Healing

Tribal cultural activities can help address historical and intergenerational trauma and feelings of cultural loss that may be underlying root causes and/or contributing factors to addiction. These can include, for example:

- Utilization of traditional healers and spiritual and traditional approaches to healing;
- Sweat lodges, sacred pipe ceremonies, smudging and other ceremonies;
- Talking circles;
- Cultural activities such as basket weaving, pottery making, drum making, canoe building, etc., depending on the Tribe;
- Cultural and linguistic immersion programs.

These traditional activities may be combined with other treatment or included in integrated treatment models, as discussed below.

> Example: Drum-Assisted Recovery Therapy for Native Americans (DARTNA) is supported by research. Drums are a sacred instrument in many American Indian and Alaska Native cultures and are often associated with ceremonies and healing. In addition to providing a sense of cultural connection, drumming may have physical and psychological effects that make it a promising focus for treatment.

> Example: Some Tribes have utilized seasonal cultural immersion camps in lieu of or in combination with residential treatment for substance use disorder. Participants practice traditional lifeways, including hunting, fishing, living in traditional dwellings and cultural and/or spiritual practices during the course of treatment.

2. Culturally Competent Integrated Treatment Models

> Example: The Swinomish Tribe designed and developed a unique treatment program called Didg^{w}álič that integrates evidence-based chemical dependency treatment with

holistic, culturally competent care to successfully deal with the effects of opioid use disorder (OUD). Didg^{w}álič provides a full array of medical and social services, utilizing a model of care that centers on and incorporates the Tribe's culture and values. The Tribal government and individual Tribal members provide cultural leadership and advice on the use of Native language and practices in the program.

Example: The Tulalip Tribe operates the Healing Lodge, a culturally sensitive transitional home facility for tribal members who are seeking to recover from addiction. In addition to a clean and sober living environment, the facility provides transportation to and from Chemical Dependency/ Mental Wellness groups and individual counseling sessions, sober support groups and cultural activities such as sweats, powwow and family nights. The program also connects residents with educational activities such as life skills trainings, budgeting, post generational trauma and Red Road to Wellbriety, a recovery and wellness program similar in some ways to the 12 Steps of AA but designed especially for Native American and following the teachings of the Medicine Wheel.

3. **Culturally Grounded Community Prevention**

Culturally competent prevention programs, tailored to each tribal community, can play an important role in stopping and reversing the spread of the opioid epidemic.

Example: The Healing of the Canoe is a collaborative project between the Suquamish Tribe, the Port Gamble S'Klallam Tribe and the University of Washington Alcohol and Drug Abuse Institute (ADAI). It has led to the development and dissemination of the Culturally Grounded Life Skills for Youth curriculum, an evidence-based, strengths-based life skills curriculum for Native youth that uses elements of a Tribe's culture to help prevent substance abuse and connect its youth to their tribal community and culture. It teaches Native youth the skills they need to navigate their life's journey without being pulled off course by alcohol or drugs, using tribal values, traditions and culture both as a compass to guide them and an anchor to ground them. By reversing the historical trauma of forced assimilation, this approach attacks the root cause of so much substance abuse among tribal youth.

Example: The Association of Village Council Presidents has responded to the opioid crisis through the Healthy Families Program, which promotes and supports whole health through the sharing, teaching, and practice of traditional values through Elluarluteng Illakutellriit - a framework illustrating the Yup'ik life cycle of traditional practices, values and beliefs from Yup'ik Elders. This framework functions alongside western and medical practices to help individuals overcome their addictions permanently.

4. **Peacekeeping and Wellness Courts**

Many Tribes have had success treating opioid offenders using traditional healing practices and alternative institutions, sometimes called wellness courts or peacekeeping courts.

Example: The Yurok Tribal Court, in coordination with the California State courts in Humboldt and Del Norte Counties, operates its Family Wellness Courts (FWC) for Yurok families suffering from opioid abuse problems. The FWC seeks to develop judicial practices that are consistent with Yurok tribal values and needs, combining the resources and expertise of both systems. It focuses on reintegrating tribal members into the culture and life of the Yurok community and helping them establish a drug-free lifestyle.

5. **Community Workforce Development and Training**

Cultural competency training as well as community workforce development can be a critical tool for addressing gaps in services, especially in rural and remote tribal communities, where it can be extremely difficult to recruit and retain qualified health care professionals.

Example: In Alaska, the Community Health Aide Program (CHAP) has increased access to medical treatment to more than 170 rural Alaskan villages utilizing a workforce development model geared toward Native people. Under CHAP, individuals selected by their communities are provided with training as community health aides and practitioners to work in rural villages under the supervision of, and in collaboration with, higher level medical professionals, often aided by telemedicine technology. As part of CHAP, behavioral health aides (BHAs) are trained as counselors, educators and advocates to help address mental health and addiction issues.

Example: Part of the Swinomish Tribe's Didgʷálič treatment model, discussed above, is training for Tribal members with a goal of building a new generation of clinically trained and culturally competent Native counselors and providers.

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Honorable Otto Tso
Speaker
24th Navajo Nation Council

MEMORANDUM

TO: Hon. Eugene Tso (Sponsor)
Hon. Stewart Wilson, Jr. (Co-Sponsor)
Hon. Carl Slater (Co-Sponsor)
24th Navajo Nation Council

FROM: Dana Bobroff
Dana Bobroff, Chief Legislative Counsel
Office of Legislative Counsel

DATE: December 15, 2022

SUBJECT: **AN ACT RELATING TO BUDGET AND FINANCE, HEALTH, EDUCATION AND HUMAN SERVICES, AND NAABIK'ÍYÁTI' COMMITTEES AND THE NAVAJO NATION COUNCIL; ESTABLISHING THE "OPIOID LITIGATION SETTLEMENT FUND"; DIRECTING THAT MONIES RECEIVED FROM *IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION, ON AUGUST 5, 2015*, MDL NO. 2804; CASE NO. 17-md-02804 AND RELATED ACTIONS BE DEPOSITED IN THE OPIOID LITIGATION SETTLEMENT FUND; REIMBURSING THE FIXED COST LITIGATION ACCOUNT FOR LITIGATION COSTS**

I have prepared the above-referenced proposed resolution and associated legislative summary sheet pursuant to your request for legislative drafting. Based on existing law and review of documents submitted, the resolution as drafted is legally sufficient. As with any action of government however, it can be subject to review by the courts in the event of proper challenge.

The Office of Legislative Counsel confirms the appropriate standing committee(s) based on the standing committees powers outlined in 2 N.N.C. §§301, 401, 501, 601 and 701. Nevertheless, "the Speaker of the Navajo Nation Council shall introduce [the proposed resolution] into the legislative process by assigning it to the respective oversight committee(s) of the Navajo Nation Council having authority over the matters for proper consideration." 2 N.N.C. §164(A)(5).

Please ensure that his particular resolution request is precisely what you want. You are encouraged to review the proposed resolution to ensure that it is drafted to your satisfaction.