EXHIBIT 4
TRIBAL ABATEMENT FUND TRUST II
TRUST DISTRIBUTION PROCEDURES

MALLINCKRODT PLC

TRIBE TRUST DISTRIBUTION PROCEDURES[1]

Issue	Description
1. APPLICABILITY OF AGREEMENT	These terms shall apply to the allocation of value received by the Tribal Abatement Fund Trust II ("**TAFT II**") under the plan of reorganization (the "**Chapter 11 Plan**" or the "**Plan**") in the Chapter 11 Cases of Mallinckrodt plc and its affiliates (collectively, "**MNK**") pending in the U.S. Bankruptcy Court for the District of Delaware (the "**Bankruptcy Court**") with respect to each American Indian or Alaska Native Tribe, band, nation, pueblo, village or community, that the U.S. Secretary of the Interior acknowledges as an Indian Tribe, as provided in the Federally Recognized Tribe List Act of 1994, 25 U.S.C. §§ 5130–5131 or Tribal Organization, as defined in 25 U.S.C. § 5304(l), (each a "**Tribe**"), whose Claims in Class 8(c) (Tribe Opioid Claims) are channeled to TAFT II under the Plan. Pursuant to the Plan, the following claims (the "**Tribe Channeled Claims**") shall be channeled to and liability shall be assumed by TAFT II as of the Effective Date: all Tribe Opioid Claims, which include any Opioid Claim against any Debtor that is held by a Tribe. The distributions made pursuant to these distribution procedures (these "**Tribe Trust Distribution Procedures**") are the exclusive distributions that will be made by TAFT II on account of the Tribe Channeled Claims; Holders of Tribe Channeled Claims will have no further or other recourse against TAFT II on account of the Tribe Channeled Claims other than what is provided for under these Tribe Trust Distribution Procedures. To the extent not explicitly reflected in the Chapter 11 Plan, the terms set forth herein will be deemed incorporated into the Chapter 11 Plan, or the trust agreement for TAFT II (the "**TAFT II Agreement**"), as applicable. These terms set forth the manner in which TAFT II shall make Abatement Distributions to the Tribes, which may be used exclusively on the parameters set forth herein.
2. PURPOSE	These Tribe Trust Distribution Procedures are intended to establish the mechanisms for the distribution and allocation of funds distributed by TAFT II to the Tribes. All such funds described in the foregoing sentence are referred to herein as "**Abatement Funds**" and shall be used to abate the opioid crisis in accordance with the terms hereof, with recognition of the culturally appropriate activities, practices, teachings or ceremonies that may, in the judgment of a Tribe or Tribal Organization, be aimed at or

[1] Terms not otherwise defined herein shall have the meaning ascribed in the Chapter 11 Plan or in the TAFT II Agreement.

Issue	Description
	supportive of remediation and abatement of the opioid crisis within a tribal community. Specifically, (i) no less than ninety five percent (95%) of the Abatement Funds distributed under the TAFT II Agreement shall be used by Tribes for abatement of the opioid crisis by funding opioid or substance use disorder related projects or programs that fall within the scope of **Schedules B** and **D** (the "**Approved Tribal Opioid Abatement Uses**"); and (ii) no more than five percent (5%) of the Abatement Funds may be used to fund administrative expenses incurred in connection with the spending of Abatement Funds for Approved Tribal Opioid Abatement Uses ("**Approved Administrative Expenses**," and, together with the Approved Tribal Opioid Abatement Uses, "**Approved Uses**"). For the avoidance of doubt, **Schedule D** is a non-exhaustive, illustrative list of culturally appropriate activities, practices, teachings or ceremonies that may, in the judgment of a Tribe or Tribal Organization, be aimed at or supportive of remediation and abatement of the opioid crisis within a tribal community. TAFT II shall, in accordance with the Plan, the Confirmation Order and the TAFT II Agreement, distribute Abatement Funds to Tribes for Approved Uses. Notwithstanding anything in these Tribe Trust Distribution Procedures that might imply to the contrary, projects or programs that constitute Approved Tribal Opioid Abatement Uses may be provided by Tribes, Tribal Organizations, tribal agencies or subdivisions or nongovernmental parties and funded from Abatement Funds.
3. DISBURSEMENT OF ABATEMENT DISTRIBUTIONS	The Chapter 11 Plan shall provide for the establishment of TAFT II and the appointment of TAFT II Trustees. The TAFT II Trustees shall distribute the Abatement Funds consistent with the Tribal Allocation Percentages set forth on **Schedule C**. The Tribal Allocation Percentages are based on the Tribal Allocation Matrix described on **Schedule E**.
4. ATTORNEYS' FEES AND COSTS FUND	Subject to the terms of the Chapter 11 Plan.

Issue	Description
5. TRIBAL ABATEMENT FUNDING	1. The allocation of distributions of Abatement Funds among Tribes will be consistent with the Tribal Allocation Percentages set forth on **Schedule C**, which will be included as part of the Tribe Trust Documents. 2. The Tribes will use the tribal allocation of Abatement Funds for programs on the approved list of abatement strategies (see **Schedule B**) and also for culturally appropriate activities, practices, teachings or ceremonies that are, in the judgment of a Tribe or Tribal Organization, aimed at or supportive of remediation and abatement of the opioid crisis within a tribal community. A list of representative examples of such culturally appropriate abatement strategies, practices, and programs is attached hereto as **Schedule D** (the "**Tribal Abatement Strategies**"). The separate allocation of abatement funding and illustrative list of Tribal Abatement Strategies recognizes that American Indian and Alaska Native Tribes and the communities they serve possess unique cultural histories, practices, wisdom, and needs that are highly relevant to the health and well-being of American Indian and Alaska Native people and that may play an important role in both individual and public health efforts and responses in Native communities. 3. The Tribes agree that Abatement Funds distributed under the Chapter 11 Plan shall be used to abate the opioid crisis in accordance with the terms of these Tribe Trust Distribution Procedures.
6. COMPLIANCE, REPORTING, AUDIT AND ACCOUNTABILITY	1. The TAFT II Trustees shall impose appropriate reporting requirements on the Tribes to ensure that Abatement Funds are used only for Approved Uses. The TAFT II Trustees may authorize modified reporting requirements for Tribes with allocations below a certain level. 2. TAFT II shall prepare an annual report (an "**Annual Report**") that shall be audited by independent auditors as provided in the TAFT II Agreement, which audited Annual Report shall be filed annually with the Bankruptcy Court. 3. The Bankruptcy Court shall have continuing jurisdiction over TAFT II, provided however, the courts of the State of Delaware, including any federal court located therein, shall also have jurisdiction over TAFT II. 4. The TAFT II Trustees shall have the power to take any and all actions that in the judgment of the TAFT II Trustees are necessary or proper to fulfill the purposes of TAFT II, including the requirement that 100% of the Abatement Funds distributed under the Plan shall be used to abate the opioid crisis in accordance with the terms hereof.

Issue	Description
	5. Notwithstanding any other provision of these Tribe Trust Distribution Procedures, the TAFT II Trustees shall implement these Tribe Trust Distribution Procedures in accordance with the Indian Self-Determination and Education Assistance Act of 1975, 25 U.S.C. 5301 *et seq*. and, for the avoidance of doubt, a Tribe, Tribal Organization or inter-tribal consortium may charge its federally-approved indirect cost rate consistent with such Act with respect to opioid abatement programs carried out by such Tribe, Tribal Organization or inter-tribal consortium.

Schedule A

(Reserved)

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 Public Creditor 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.

Schedule C
Tribe Beneficiaries and Tribal Allocation Percentages

Mallinckrodt - Allocation of Settlement Among Tribes

October 2021

Federally Recognized Tribe Name	Division of Funds (Allocation %)
Total	**100.0000%**
Absentee-Shawnee Tribe of Indians of Oklahoma	0.5575%
Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation, California	0.0406%
Ak-Chin Indian Community	0.0635%
Alabama-Coushatta Tribe of Texas	0.0293%
Alabama-Quassarte Tribal Town	0.0111%
ALL Alaskan Tribes	9.2643%
Alaska Native Tribal Health Consortium	1.8883%
*Aleutian Pribilof Islands Association	0.0674%
*Arctic Slope Native Association	0.2825%
*Bristol Bay Area Health Corporation	0.4733%
Chickaloon Native Village	0.0105%
*Chugachmiut	0.1055%
*Copper River Native Association	0.0922%
*Eastern Aleutian Tribes	0.1017%
Eklutna Native Village	0.0125%
Eyak Native Village	0.0202%
*Kodiak Area Native Association	0.1817%
*Kenaitze Indian Tribe	0.1544%
*Ketchikan Indian Community	0.1033%
Knik Tribe	0.0118%
*Maniilaq Association	0.4026%
Metlakatla Indian Community	0.0703%
*Mt. Sanford Tribal Consortium	0.0268%
*Norton Sound Health Corporation	0.5929%
*Southcentral Foundation	1.5145%
*Southeast Alaska Regional Health Corporation	0.5865%
Seldovia Village Tribe	0.0322%
*Tanana Chiefs Conference (including Council of Athabascan Tribal Governments)	0.9318%
Yakutat Tlingit Tribe	0.0290%
*Yukon Kuskokwim Health Corporation	1.4987%
Native Village of Chitina	0.0115%
Ninilchik Village	0.0289%
Native Village of Tanana	0.0190%
Native Village of Tyonek	0.0145%
Alturas Indian Rancheria, California	0.0008%
Apache Tribe of Oklahoma	0.1334%
Arapaho Tribe of the Wind River Reservation, Wyoming	0.3444%
Aroostook Band of Micmacs	0.0370%
Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana	0.3789%
Augustine Band of Cahuilla Indians, California	0.0013%
Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, Wisconsin	0.1533%
Bay Mills Indian Community, Michigan	0.0714%
Bear River Band of the Rohnerville Rancheria, California	0.0507%
Berry Creek Rancheria of Maidu Indians of California	0.1121%
Big Lagoon Rancheria, California	0.0027%
Big Pine Paiute Tribe of the Owens Valley	0.0320%
Big Sandy Rancheria of Western Mono Indians of California	0.0328%
Big Valley Band of Pomo Indians of the Big Valley Rancheria, California	0.1214%
Bishop Paiute Tribe	0.1041%
Blackfeet Tribe of the Blackfeet Indian Reservation of Montana	0.5378%

FederallyRecognizedTribeName	Division of Funds (Allocation %)
Blue Lake Rancheria, California	0.0038%
Bois Forte (Nett Lake) Band of the Minnesota Chippewa Tribe, Minnesota	0.0820%
Bridgeport Indian Colony	0.0026%
Buena Vista Rancheria of Me-Wuk Indians of California	0.0034%
Burns Paiute Tribe	0.0116%
Cabazon Band of Mission Indians, California	0.0017%
Cachil DeHe Band of Wintun Indians of the Colusa Indian Community of the Colusa Rancheria, California	0.0056%
Caddo Nation of Oklahoma	0.1084%
Cahto Tribe of the Laytonville Rancheria	0.0207%
Cahuilla Band of Indians	0.0368%
California Valley Miwok Tribe, California	0.0044%
Campo Band of Diegueno Mission Indians of the Campo Indian Reservation, California	0.0241%
Catawba Indian Nation	0.0743%
Cayuga Nation	0.0070%
Cedarville Rancheria, California	0.0019%
Chemehuevi Indian Tribe of the Chemehuevi Reservation, California	0.0181%
Cher-Ae Heights Indian Community of the Trinidad Rancheria, California	0.0200%
Cherokee Nation	12.1894%
Cheyenne and Arapaho Tribes, Oklahoma	0.7723%
Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota	0.2906%
Chickahominy Indian Tribe	0.0315%
Chickahominy Indian Tribe—Eastern Division	0.0085%
Chickasaw Nation	2.1567%
Chicken Ranch Rancheria of Me-Wuk Indians of California	0.0026%
Chippewa Cree Indians of the Rocky Boy's Reservation, Montana	0.2330%
Chitimacha Tribe of Louisiana	0.0347%
Choctaw Nation of Oklahoma	5.4805%
Citizen Potawatomi Nation, Oklahoma	1.4669%
Cloverdale Rancheria of Pomo Indians of California	0.0518%
Cocopah Tribe of Arizona	0.0366%
Coeur D'Alene Tribe	0.2865%
Cold Springs Rancheria of Mono Indians of California	0.0108%
Colorado River Indian Tribes of the Colorado River Indian Reservation, Arizona and California	0.2784%
Comanche Nation, Oklahoma	0.6989%
Confederated Salish and Kootenai Tribes of the Flathead Reservation	0.6040%
Confederated Tribes and Bands of the Yakama Nation	0.6242%
Confederated Tribes of Siletz Indians of Oregon	0.4294%
Confederated Tribes of the Chehalis Reservation	0.0887%
Confederated Tribes of the Colville Reservation	0.4214%
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians	0.0541%
Confederated Tribes of the Goshute Reservation, Nevada and Utah	0.0144%
Confederated Tribes of the Grand Ronde Community of Oregon	0.2456%
Confederated Tribes of the Umatilla Indian Reservation	0.1554%
Confederated Tribes of the Warm Springs Reservation of Oregon	0.3374%
Coquille Indian Tribe	0.0926%
Coushatta Tribe of Louisiana	0.0264%
Cow Creek Band of Umpqua Tribe of Indians	0.1532%
Cowlitz Indian Tribe	0.4024%
Coyote Valley Band of Pomo Indians of California	0.0337%
Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota	0.1504%
Crow Tribe of Montana	0.7579%
Delaware Nation, Oklahoma	0.0342%
Delaware Tribe of Indians	0.3134%

FederallyRecognizedTribeName	Division of Funds (Allocation %)
Dry Creek Rancheria Band of Pomo Indians, California	0.0709%
Duckwater Shoshone Tribe of the Duckwater Reservation, Nevada	0.0224%
Eastern Band of Cherokee Indians	0.9560%
Eastern Shawnee Tribe of Oklahoma	0.0548%
Eastern Shoshone Tribe of the Wind River Reservation, Wyoming	0.1459%
Elem Indian Colony of Pomo Indians of the Sulphur Bank Rancheria, California	0.0101%
Elk Valley Rancheria, California	0.0063%
Ely Shoshone Tribe of Nevada	0.0550%
Enterprise Rancheria of Maidu Indians of California	0.1825%
Ewiiaapaayp Band of Kumeyaay Indians, California	0.0004%
Federated Indians of Graton Rancheria, California	0.0770%
Flandreau Santee Sioux Tribe of South Dakota	0.0224%
Fond du Lac Band of the Minnesota Chippewa Tribe, Minnesota	0.3382%
Forest County Potawatomi Community, Wisconsin	0.0266%
Fort Belknap Indian Community of the Fort Belknap Reservation of Montana	0.1662%
Fort Bidwell Indian Community of the Fort Bidwell Reservation of California	0.0088%
Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation, California	0.0104%
Fort McDermitt Paiute and Shoshone Tribes of the Fort McDermitt Indian Reservation, Nevada and Oregon	0.0212%
Fort McDowell Yavapai Nation, Arizona	0.0852%
Fort Mojave Indian Tribe of Arizona, California & Nevada	0.1614%
Fort Sill Apache Tribe of Oklahoma	0.0194%
Gila River Indian Community of the Gila River Indian Reservation, Arizona	2.5642%
Grand Portage Band of the Minnesota Chippewa Tribe, Minnesota	0.0211%
Grand Traverse Band of Ottawa and Chippewa Indians, Michigan	0.1041%
Greenville Rancheria	0.0942%
Grindstone Indian Rancheria of Wintun-Wailaki Indians of California	0.0255%
Guidiville Rancheria of California	0.0137%
Habematolel Pomo of Upper Lake, California	0.0275%
Hannahville Indian Community, Michigan	0.0279%
Havasupai Tribe of the Havasupai Reservation, Arizona	0.0325%
Ho-Chunk Nation of Wisconsin	0.2791%
Hoh Indian Tribe	0.0032%
Hoopa Valley Tribe, California	0.2647%
Hopi Tribe of Arizona	0.4475%
Hopland Band of Pomo Indians, California	0.0723%
Houlton Band of Maliseet Indians	0.0350%
Hualapai Indian Tribe of the Hualapai Indian Reservation, Arizona	0.2240%
Iipay Nation of Santa Ysabel, California	0.0136%
Inaja Band of Diegueno Mission Indians of the Inaja and Cosmit Reservation, California	0.0008%
Ione Band of Miwok Indians of California	0.1215%
Iowa Tribe of Kansas and Nebraska	0.0527%
Iowa Tribe of Oklahoma	0.0959%
Jackson Band of Miwuk Indians	0.0054%
Jamestown S'Klallam Tribe	0.0344%
Jamul Indian Village of California	0.0082%
Jena Band of Choctaw Indians	0.0116%
Jicarilla Apache Nation, New Mexico	0.2812%
Kaibab Band of Paiute Indians of the Kaibab Indian Reservation, Arizona	0.0158%
Kalispel Indian Community of the Kalispel Reservation	0.0374%
Karuk Tribe	0.2540%
Kashia Band of Pomo Indians of the Stewarts Point Rancheria, California	0.0043%
Kaw Nation, Oklahoma	0.1314%
Kewa Pueblo, New Mexico	0.1155%

FederallyRecognizedTribeName	Division of Funds (Allocation %)
Keweenaw Bay Indian Community, Michigan	0.1080%
Kialegee Tribal Town	0.0174%
Kickapoo Traditional Tribe of Texas	0.0175%
Kickapoo Tribe of Indians of the Kickapoo Reservation in Kansas	0.0580%
Kickapoo Tribe of Oklahoma	0.5597%
Kiowa Indian Tribe of Oklahoma	0.4367%
Klamath Tribes	0.1776%
Kletsel Dehe Band of Wintun Indians	0.0363%
Koi Nation of Northern California	0.0140%
Kootenai Tribe of Idaho	0.0097%
La Jolla Band of Luiseno Indians, California	0.0372%
La Posta Band of Diegueno Mission Indians of the La Posta Indian Reservation, California	0.0030%
Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin	0.1611%
Lac du Flambeau Band of Lake Superior Chippewa Indians of the Lac du Flambeau Reservation of Wisconsin	0.2145%
Lac Vieux Desert Band of Lake Superior Chippewa Indians of Michigan	0.0310%
Las Vegas Tribe of Paiute Indians of the Las Vegas Indian Colony, Nevada	0.3560%
Leech Lake Band of the Minnesota Chippewa Tribe, Minnesota	0.3876%
Little River Band of Ottawa Indians, Michigan	0.0925%
Little Shell Tribe of Chippewa Indians of Montana	0.2023%
Little Traverse Bay Bands of Odawa Indians, Michigan	0.1765%
Lone Pine Paiute-Shoshone Tribe	0.0210%
Los Coyotes Band of Cahuilla and Cupeno Indians, California	0.0157%
Lovelock Paiute Tribe of the Lovelock Indian Colony, Nevada	0.0173%
Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota	0.0499%
Lower Elwha Tribal Community	0.0686%
Lower Sioux Indian Community in the State of Minnesota	0.0236%
Lummi Tribe of the Lummi Reservation	0.2100%
Lytton Rancheria of California	0.0238%
Makah Indian Tribe of the Makah Indian Reservation	0.1833%
Manchester Band of Pomo Indians of the Manchester Rancheria, California	0.0819%
Manzanita Band of Diegueno Mission Indians of the Manzanita Reservation, California	0.0046%
Mashantucket Pequot Indian Tribe	0.0369%
Mashpee Wampanoag Tribe	0.0687%
Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan	0.0175%
Mechoopda Indian Tribe of Chico Rancheria, California	0.1655%
Menominee Indian Tribe of Wisconsin	0.2586%
Mesa Grande Band of Diegueno Mission Indians of the Mesa Grande Reservation, California	0.0337%
Mescalero Apache Tribe of the Mescalero Reservation, New Mexico	0.2753%
Miami Tribe of Oklahoma	0.0514%
Miccosukee Tribe of Indians	0.0269%
Middletown Rancheria of Pomo Indians of California	0.0260%
Mille Lacs Band of the Minnesota Chippewa Tribe, Minnesota	0.1295%
Mississippi Band of Choctaw Indians	0.4540%
Moapa Band of Paiute Indians of the Moapa River Indian Reservation, Nevada	0.0431%
Modoc Nation	0.0054%
Mohegan Tribe of Indians of Connecticut	0.0666%
Monacan Indian Nation	0.0588%
Mooretown Rancheria of Maidu Indians of California	0.1949%
Morongo Band of Mission Indians, California	0.0795%
Muckleshoot Indian Tribe	0.2826%
Muscogee (Creek) Nation	2.8659%
Nansemond Indian Nation	0.0071%
Narragansett Indian Tribe	0.0435%

FederallyRecognizedTribeName	Division of Funds (Allocation %)
Navajo Nation, Arizona, New Mexico & Utah	15.2207%
Nez Perce Tribe	0.2349%
Nisqually Indian Tribe	0.0661%
Nooksack Indian Tribe	0.0494%
Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana	0.2535%
Northfork Rancheria of Mono Indians of California	0.1192%
Northwestern Band of the Shoshone Nation	0.0046%
Nottawaseppi Huron Band of the Potawatomi, Michigan	0.0735%
Oglala Sioux Tribe	0.9582%
Ohkay Owingeh, New Mexico	0.2226%
Omaha Tribe of Nebraska	0.1098%
Oneida Indian Nation	0.0792%
Oneida Nation	0.6249%
Onondaga Nation	0.0286%
Osage Nation	0.2998%
Otoe-Missouria Tribe of Indians, Oklahoma	0.1412%
Ottawa Tribe of Oklahoma	0.0294%
Paiute Indian Tribe of Utah (Cedar Band of Paiutes, Kanosh Band of Paiutes, Koosharem Band of Paiutes, Indian Peaks Band of Paiutes, and Shivwits Band of Paiutes)	0.0864%
Paiute-Shoshone Tribe of the Fallon Reservation and Colony, Nevada	0.1593%
Pala Band of Mission Indians	0.0654%
Pamunkey Indian Tribe	0.0149%
Pascua Yaqui Tribe of Arizona	0.6028%
Paskenta Band of Nomlaki Indians of California	0.0061%
Passamaquoddy Tribe Indian Township	0.0601%
Passamaquoddy Tribe Pleasant Point	0.0758%
Pauma Band of Luiseno Mission Indians of the Pauma & Yuima Reservation, California	0.0135%
Pawnee Nation of Oklahoma	0.1674%
Pechanga Band of Luiseno Mission Indians of the Pechanga Reservation, California	0.1620%
Penobscot Nation	0.1004%
Peoria Tribe of Indians of Oklahoma	0.0425%
Picayune Rancheria of Chukchansi Indians of California	0.0820%
Pinoleville Pomo Nation, California	0.0269%
Pit River Tribe, California (includes XL Ranch, Big Bend, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias)	0.1144%
Poarch Band of Creeks	0.1346%
Pokagon Band of Potawatomi Indians, Michigan and Indiana	0.1197%
Ponca Tribe of Indians of Oklahoma	0.2376%
Ponca Tribe of Nebraska	0.1290%
Port Gamble S'Klallam Tribe	0.0841%
Potter Valley Tribe, California	0.0005%
Prairie Band Potawatomi Nation	0.0680%
Prairie Island Indian Community in the State of Minnesota	0.0030%
Pueblo of Acoma, New Mexico	0.1776%
Pueblo of Cochiti, New Mexico	0.0602%
Pueblo of Isleta, New Mexico	0.9641%
Pueblo of Jemez, New Mexico	0.4715%
Pueblo of Laguna, New Mexico	0.3010%
Pueblo of Nambe, New Mexico	0.0678%
Pueblo of Picuris, New Mexico	0.0148%
Pueblo of Pojoaque, New Mexico	0.0364%
Pueblo of San Felipe, New Mexico	0.1962%
Pueblo of San Ildefonso, New Mexico	0.0515%
Pueblo of Sandia, New Mexico	0.0539%

FederallyRecognizedTribeName	Division of Funds (Allocation %)
Pueblo of Santa Ana, New Mexico	0.1216%
Pueblo of Santa Clara, New Mexico	0.0972%
Pueblo of Taos, New Mexico	0.1254%
Pueblo of Tesuque, New Mexico	0.0368%
Pueblo of Zia, New Mexico	0.1135%
Puyallup Tribe of the Puyallup Reservation	0.3461%
Pyramid Lake Paiute Tribe of the Pyramid Lake Reservation, Nevada	0.2112%
Quapaw Nation	0.0677%
Quartz Valley Indian Community of the Quartz Valley Reservation of California	0.0209%
Quechan Tribe of the Fort Yuma Indian Reservation, California & Arizona	0.2304%
Quileute Tribe of the Quileute Reservation	0.0445%
Quinault Indian Nation	0.1554%
Ramona Band of Cahuilla, California	0.0016%
Rappahannock Tribe, Inc.	0.0068%
Red Cliff Band of Lake Superior Chippewa Indians of Wisconsin	0.0680%
Red Lake Band of Chippewa Indians, Minnesota	0.3333%
Redding Rancheria, California	0.3258%
Redwood Valley or Little River Band of Pomo Indians of the Redwood Valley Rancheria California	0.0214%
Reno-Sparks Indian Colony, Nevada	0.4667%
Resighini Rancheria, California	0.0117%
Rincon Band of Luiseno Mission Indians of the Rincon Reservation, California	0.0301%
Robinson Rancheria	0.0577%
Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota	0.3906%
Round Valley Indian Tribes, Round Valley Reservation, California	0.1304%
Sac & Fox Nation of Missouri in Kansas and Nebraska	0.0066%
Sac & Fox Nation, Oklahoma	0.4786%
Sac & Fox Tribe of the Mississippi in Iowa	0.0652%
Saginaw Chippewa Indian Tribe of Michigan	0.1612%
Saint Regis Mohawk Tribe	0.3164%
Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona	0.3690%
Samish Indian Nation	0.0508%
San Carlos Apache Tribe of the San Carlos Reservation, Arizona	0.9842%
San Juan Southern Paiute Tribe of Arizona	0.0052%
San Manuel Band of Mission Indians, California	0.0212%
San Pasqual Band of Diegueno Mission Indians of California	0.0096%
Santa Rosa Band of Cahuilla Indians, California	0.0163%
Santa Rosa Indian Community of the Santa Rosa Rancheria, California	0.0567%
Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California	0.0489%
Santee Sioux Nation, Nebraska	0.0407%
Sauk-Suiattle Indian Tribe	0.0041%
Sault Ste. Marie Tribe of Chippewa Indians, Michigan	0.7720%
Scotts Valley Band of Pomo Indians of California	0.0140%
The Seminole Nation of Oklahoma	0.4506%
Seminole Tribe of Florida	0.4524%
Seneca Nation of Indians	0.4387%
Seneca-Cayuga Nation	0.0727%
Shakopee Mdewakanton Sioux Community of Minnesota	0.0040%
Shawnee Tribe	0.0385%
Sherwood Valley Rancheria of Pomo Indians of California	0.0390%
Shingle Springs Band of Miwok Indians, Shingle Springs Rancheria (Verona Tract), California	0.0578%
Shinnecock Indian Nation	0.0136%
Shoalwater Bay Indian Tribe of the Shoalwater Bay Indian Reservation	0.0388%
Shoshone-Bannock Tribes of the Fort Hall Reservation	0.2571%

FederallyRecognizedTribeName	Division of Funds (Allocation %)
Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada	0.1081%
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota	0.2481%
Skokomish Indian Tribe	0.0492%
Skull Valley Band of Goshute Indians of Utah	0.0031%
Snoqualmie Indian Tribe	0.0268%
Soboba Band of Luiseno Indians, California	0.1192%
Sokaogon Chippewa Community, Wisconsin	0.0119%
Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado	0.0816%
Spirit Lake Tribe, North Dakota	0.1358%
Spokane Tribe of the Spokane Reservation	0.1194%
Squaxin Island Tribe of the Squaxin Island Reservation	0.0474%
St. Croix Chippewa Indians of Wisconsin	0.0720%
Standing Rock Sioux Tribe of North & South Dakota	0.2451%
Stillaguamish Tribe of Indians of Washington	0.0069%
Stockbridge Munsee Community, Wisconsin	0.0656%
Summit Lake Paiute Tribe of Nevada	0.0045%
Suquamish Indian Tribe of the Port Madison Reservation	0.0385%
Susanville Indian Rancheria, California	0.0940%
Swinomish Indian Tribal Community	0.0685%
Syeuan Band of the Kumeyaay Nation	0.0050%
Table Mountain Rancheria	0.0008%
Tejon Indian Tribe	0.0230%
Te-Moak Tribe of Western Shoshone Indians of Nevada (Four constituent bands: Battle Mountain Band; Elko Band; South Fork Band and Wells Band)	0.1564%
Thlopthlocco Tribal Town	0.0385%
Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota	0.2170%
Timbisha Shoshone Tribe	0.0061%
Tohono O'odham Nation of Arizona	1.4176%
Tolowa Dee-ni' Nation	0.1350%
Tonawanda Band of Seneca	0.0103%
Tonkawa Tribe of Indians of Oklahoma	0.0387%
Tonto Apache Tribe of Arizona	0.0187%
Torres Martinez Desert Cahuilla Indians, California	0.0496%
Tulalip Tribes of Washington	0.3139%
Tule River Indian Tribe of the Tule River Reservation, California	0.1030%
Tunica-Biloxi Indian Tribe	0.0183%
Tuolumne Band of Me-Wuk Indians of the Tuolumne Rancheria of California	0.0252%
Turtle Mountain Band of Chippewa Indians of North Dakota	0.4382%
Tuscarora Nation	0.0127%
Twenty-Nine Palms Band of Mission Indians of California	0.0023%
United Auburn Indian Community of the Auburn Rancheria of California	0.3284%
United Keetoowah Band of Cherokee Indians in Oklahoma	0.1820%
Upper Mattaponi Tribe	0.0194%
Upper Sioux Community, Minnesota	0.0055%
Upper Skagit Indian Tribe	0.0250%
Ute Indian Tribe of the Uintah & Ouray Reservation, Utah	0.3345%
Ute Mountain Ute Tribe	0.1348%
Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation, California	0.0030%
Capitan Grande Band of Diegueno Mission Indians of California (Barona Group of Capitan Grande Band of Mission Indians of the Barona Reservation, California; Viejas (Baron Long) Group of Capitan Grande Band of Mission Indians of the Viejas Reservation, California)	0.0639%
Walker River Paiute Tribe, Nevada	0.0922%
Wampanoag Tribe of Gay Head (Aquinnah)	0.0216%
Washoe Tribe of Nevada & California	0.2416%

FederallyRecognizedTribeName	Division of Funds (Allocation %)
White Earth Band of the Minnesota Chippewa Tribe, Minnesota	0.3129%
White Mountain Apache Tribe of the Fort Apache Reservation, Arizona	1.2832%
Wichita and Affiliated Tribes, Oklahoma	0.1054%
Wilton Rancheria, California	0.0764%
Winnebago Tribe of Nebraska	0.1438%
Winnemucca Indian Colony of Nevada	0.0121%
Wiyot Tribe, California	0.0513%
Wyandotte Nation	0.0858%
Yankton Sioux Tribe of South Dakota	0.1301%
Yavapai-Apache Nation of the Camp Verde Indian Reservation, Arizona	0.1642%
Yavapai-Prescott Indian Tribe	0.0463%
Yerington Paiute Tribe of the Yerington Colony & Campbell Ranch, Nevada	0.0546%
Yocha Dehe Wintun Nation, California	0.0091%
Yomba Shoshone Tribe of the Yomba Reservation, Nevada	0.0162%
Ysleta del Sur Pueblo	0.0531%
Yurok Tribe of the Yurok Reservation, California	0.4941%
Zuni Tribe of the Zuni Reservation, New Mexico	0.4432%

** 50% of the allocation to this entity shall be made available to federally recognized tribes served by the entity.*

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 Didg^{w}álič 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.

Schedule E
Tribal Allocation Matrix

The Tribal Nation's 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. Data are "imputed" to a Tribe by estimation based on population when the data is only available on a county or statewide basis. In the case of MMEs and drug overdose rates, the imputation of the data to a tribal population is multiplied by a "disproportionate impact" adjustment reflecting the higher incidence of opioid use disorder and prescription opioid overdose deaths in tribal communities.

Two computations are undertaken for all Tribes, and then combined together. 85% of a Tribe's matrix share is calculated by considering its imputed MME rate (50%), overdose rates (40%), and poverty rate (10%) as applied to its IHS user population. 15% of a Tribe's matrix share is calculated by considering the same three elements, similarly weighted, as applied to the Tribe's citizenship data. Once these two matrix results are combined, the resulting share is further adjusted by each Tribe's relative cost of living. COLA adjustments are done on a regional basis and are weighted at 10%, resulting in modest adjustments ranging from 1.3% down to 2.4% up.

Data for Alaska Tribes was initially computed on a statewide basis, and the resulting matrix share for Alaska was then subdivided among Alaska Tribes and tribal organizations participating in the Alaska Tribal Health Compact (employing the same methodology historically used to allocate certain other tribal health care funds across Alaska tribal health care providers).

The matrix allocates individual amounts to each California Tribe, although four intertribal health care providers in California have also separately filed litigation. Each such intertribal provider will engage in discussions with its member tribes and agree on an amount that the member tribes will allocate from their funds to the intertribal provider.

Tribal citizenship data used in the matrix was subject to a tribal verification process (except for Alaska, where data was drawn from the U.S. Census). In instances where IHS user population data for multiple Tribes was not allocated by IHS to individual Tribes, user populations were prorated across the Tribes within an IHS service unit based on the Tribes' relative tribal citizenship.