March 2024

Opioid Settlement Funds Report

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Introduction

Overdose deaths from opioids are an ongoing public health crisis in the United States. Over the last two decades, more than 500,000 people have died from opioid overdoses.[1] In 2021, 60% of overdose deaths in Iowa involved opioids.[2]

Opioids are a class of drugs that can be used to reduce pain. There are a few different types of opioids that have contributed to the rise in overdoses.

- **Prescription Opioids:** These medications can help with moderate to severe pain, but can also have serious risks and side effects, including addiction, abuse, and overdose. Examples of prescription opioids include oxycodone, hydrocodone, morphine, and methadone.
- **Heroin:** Heroin is an illegal and highly addictive opioid that is typically injected but can also be smoked or snorted. Overdosing on heroin can lead to slow and shallow breathing, coma, and death.
- **Fentanyl:** Fentanyl is a synthetic opioid that is approximately 50 times more potent than heroin and 100 times more potent than morphine. It is approved for treating extremely severe pain, but it is also illegally made and distributed. Fentanyl is often combined with other substances, such as heroin and/or cocaine, without the user's knowledge. In 2013, overdose deaths involving synthetic opioids, particularly fentanyl, significantly increased.[3]

Overview of Settlement Funds

As a result of litigation brought against opioid manufacturers, distributors, and dispensers, states, territories, and thousands of local governments across the country have started to receive funds from the settlements for approved opioid remediation uses. As each opioid involved entity settles its litigation, there are unique terms to the amounts, payment structures, and timelines for that entity. As of February 2024, Scott County has received approximately $1.7 million of an anticipated $6.8 million dollars to be received by 2039. The one constant between the settlements is how the funds are directed for use.

Exhibit E (Attachment 1) lists allowable opioid remediation uses identified in the settlement. Strategies within Schedule A are "core abatement strategies", indicating there is a strong evidence base to support their use. The nine core abatement strategies are described in the table below and can be found in Attachment 2 (Primer on Spending Funds from the Opioid Litigation – Johns Hopkins Bloomberg School of Public Health).

Strategy	Evidence of Effectiveness
Core Strategy #1: Broaden access to naloxone	Increasing the distribution of naloxone in the community is associated with fewer overdose deaths.
Core Strategy #2: Increase use of medications to treat opioid use disorder	Medications (methadone and buprenorphine) are the most effective treatments for people with opioid use

	disorder. They reduce cravings and withdrawal symptoms and decrease the risk of overdose death.
Core Strategy #3: Provide treatment and supports during pregnancy and the postpartum period	Similar to treatment for people who are not pregnant, medications (methadone and buprenorphine) are the evidence-based standard of care.
Core Strategy #4: Expand services for neonatal opioid withdrawal syndrome	Providing peripartum care with evidence-based models to children and families helps promote normal development and success later in life.
Core Strategy #5: Fund warm hand-off programs and recovery services	Holistic recovery support services have been proven to assist individuals in starting treatment and connecting to support services.
Core Strategy #6: Improve treatment in jails and prisons	Starting treatment with medications (methadone and buprenorphine) while people with an opioid use disorder are still incarcerated has been shown to reduce overdose deaths and illicit opioid use.
Core Strategy #7: Enrich evidence-based prevention strategies	Evidence-based youth primary prevention programs have been proven to reduce risky behaviors, including drug misuse.
Core Strategy #8: Expand harm reduction programs	Harm reduction services have been shown to reduce overdose deaths, prevent blood-borne infections (e.g., HIV and hepatitis C), and chronic diseases.
Core Strategy #9: Support data collection and research	Data surveillance and program evaluation can assist jurisdictions in determining if strategies to address the opioid crisis are working or if new approaches are needed.

Overview of Scott County Strategic Planning Process

The Scott County Community Services and Health Departments were asked to lead the community planning process for Scott County to determine how to best use the dollars according to the approved strategies. In January 2023, representatives from each department formed the Core Team and met to start discussing this process. Both departments were committed to facilitating a process that would capture community need and input. Health Department staff were familiar with using the Mobilizing for Action through Planning and Partnerships (MAPP) process. The MAPP process is an evidence-based framework developed by the National Association for County and City Health Officials (NACCHO) that is reliant on community engagement to identify community needs and align them with resources to address

them. The team decided to use a modified MAPP process within a shorter timeframe to guide planning efforts for the opioid settlement funds.

The Core Team presented an overview of the settlement funds, the proposed process, and timeline for completion to the Scott County Board of Supervisors (BOS) in June 2023. Included in the projected timeline was the establishment of a Steering Committee by the end of summer, the facilitation of a strategic planning process within 3-6 months, and presentation of recommendations to the BOS in early 2024.

Involvement in the planning process involved representatives from sectors across the community:

- **Core Team:** This group completed the day-to-day work of planning and facilitating the process and included staff from Scott County Community Services and Health Departments.
- **Opioid Settlement Steering Committee:** This group included representatives from sectors listed in the table below. The Core Team brainstormed sectors, organizations, and individuals to participate in the Steering Committee. Members were asked to assist with the following functions: participate in meetings and engage other partners in specific tasks; bring specific knowledge of opioid use issues to the table; assist with an opioid use needs assessment and prioritization of use of settlement funds; access data specific to their sector; recruit community members to participate in information gathering (surveys, focus groups, one-on-ones, etc.); ensure the sustainability of the assessment process; and publicize the process, activities, and results to partner organizations and residents.

Steering Committee Members & Sectors

Opioid Settlement Steering Committee	
Name	**Organization**
Adam Holland	City of Davenport
Amy Thoreson	Scott County Health Department
Angela Ganzer Bovitz	Genesis Health System
Austin Gross	Rosecrance
Becca Pratt	Center for Behavioral Health
Brooke Barnes	Scott County Health Department
Brooke Weber	Main at Locust
Bryce Schmidt	Scott County Sheriff's Office
Chuck Gipson	MEDIC EMS of Scott County
Dakotah Smith	One Eighty
Dennis Duke	UnityPoint Health – Trinity
Ellen Gackle	Scott County Health Department
Erin Sodawasser-Hermiston	St. Ambrose University
Erin Taylor	Vera French Community Mental Health Center
Jeff Reiter	City of Bettendorf

Laura Rodriguez	Iowa Harm Reduction Coalition – Quad Cities
Lori Elam	Scott County Community Services
Mary Petersen	Center for Alcohol & Drug Services, Inc. (CADS)
Melissa Sharer	St. Ambrose University
Nicole Hanna	Main at Locust
Rich Whitaker	Vera French Community Mental Health Center
Sarah Harris	Public School Districts' Designated Representative
Tiffany Peterson	Scott County Health Department
Tom Bowman	Community Health Care, Inc. (CHC)

Overview of Steering Committee Meetings & Prioritization Process

Steering Committee Meeting: July 2023

The Opioid Settlement Steering Committee met for the first time in July 2023. Core Team members provided an overview of the settlement funds. Steering Committee members were oriented to the Mobilizing for Action through Planning and Partnership (MAPP) process, received an overview of the approved settlement strategies, and reviewed initial data that had been collected. Committee members discussed the current impact of opioid use in their sector and started brainstorming what barriers and resources exist in the community.

The Bloomberg School of Public Health at Johns Hopkins developed resources to assist local jurisdictions in determining how to spend opioid settlement funds. The Core Team shared the Principles for the Use of Funds from the Opioid Litigation (Attachment 3) resource with the Steering Committee at the first meeting to establish the group's purpose for this process.

1. Spend money to save lives.
2. Use evidence to guide spending.
3. Invest in youth prevention.
4. Focus on racial equity.
5. Develop a fair and transparent process for deciding where to spend the funding.

Steering Committee Meeting: August 2023

At the second meeting in August 2023, members began listing what resources and services already exist in the community within each component of the Substance Abuse and Mental Health Services Administration (SAHMSA) Continuum of Care model (prevention, treatment/harm reduction, and recovery). The group also brainstormed additional organizations or groups to talk with about opioid use in the county. Following this meeting, Steering Committee members were asked to collect relevant local data from their agencies and assist with the coordination and facilitation of subpopulation focus groups.

Steering Committee Meeting: October 2023

The Core Team provided an overview of the focus groups that had been conducted and major themes within each component of the continuum of care at the third meeting in October 2023.

Steering Committee members reflected on the results of the focus groups by working through a series of questions: what stands out, what appears to be a central issue or key problem area, what insights are beginning to emerge, and what are the first steps that need to be taken.

Overview of Needs Assessment

Quantitative

Core Team members started gathering both secondary data and local data from community partners in the summer of 2023. This included state, county, and city level data. Some major themes of the quantitative data are summarized below. The full list of indicators and themes can be found in the Opioid Data Overview Document (Attachment 4).

Indicator	Themes
Youth Use	Data from the 2021 Iowa Youth Survey showed that youth use of prescription medications for non-medical reasons in Scott County mirrored percentages for all youth in the state of Iowa.
Overdose Emergency Department Visits	Emergency department visits for overdose in Scott County totaled 326 in 2022, which was the second highest number when compared to other counties in Iowa.
911 Calls with Narcan Administration	Data from MEDIC EMS showed an increasing number of 911 calls with Narcan administration between 2009 (27) to 2022 (348). Part of this increase was due to changes in internal procedures for when to administer the opioid reversal medication.
Opioid-Related Encounters	Data from both local hospital systems (Genesis and UnityPoint) on the number of opioid-related encounters showed the majority of encounters occurring in emergency department and clinic settings. At Genesis, encounters were highest among the 66+ year old population. At UnityPoint, encounters were highest among the 25-35 year old population.
Prescription Monitoring Program	When compared to the other large counties in Iowa (Black Hawk, Johnson, Linn, and Polk), the rate of opioid prescriptions per 10,000 population in Scott County ranked second highest. Opioid prescriptions were higher among the older age groups (55+). For opiate antagonist prescriptions, Scott County ranked fifth compared to the other large counties.
Harm Reduction Initiatives	The Iowa Harm Reduction Coalition – Quad Cities provided data on harm reduction supplies being distributed in the community. There were 361 opioid overdose reversals reported and 3,252 naloxone kits dispensed through mid-August 2023. Of individuals who were given the naloxone kits, 21% were unhoused, 67% were male, and 23% were Black.
Recovery Ecosystem Index Score	This tool indicated the number of substance use treatment facilities per 10,000 population and the number of buprenorphine providers per 10,000 population in Scott County were lower than the averages for the state of Iowa and the U.S.

Qualitative

Focus Groups Process

Several focus groups were held in October and November of 2023 with the following subpopulations: faith sector, healthcare providers, people with lived experience, jail programming and reentry services, youth, and individuals experiencing homelessness/housing insecurity. Members of the Steering Committee were asked to assist with brainstorming subpopulations to engage, make connections to contacts, and facilitate focus groups if they were comfortable doing so. Core Team members drafted a Facilitator's Guide (Attachment 5) to assist Steering Committee members with conducting the focus groups.

The guide included a description of the purpose of the focus groups, which was to gain feedback from community members on the impact of opioid use in Scott County and how it can be addressed. A verbal consent section explained that participants could stop participating at any time and that all responses would remain anonymous to protect confidentiality. The facilitator's guide included a bank of questions that facilitators could choose from to tailor the questions to the focus group subpopulation. A demographic profile of focus group participants can be found in Attachment 6.

Focus Groups Themes

Focus group participants gave input on how opioid use impacts Scott County, what resources and services are available, and what else is needed to address opioid use and overdoses. Since not all participants were asked the same set of questions, responses were organized into the different components of the Substance Abuse and Mental Health Administration's (SAMHSA) Continuum of Care model of care (prevention, treatment, harm reduction, and recovery) for analysis. Common themes are highlighted in the table below along with quotes as examples.

Prevention
Education to children, prescribers, and the community
• *"Need to look at preventative measures to address issues before they become a problem."* • *"They [doctors] never explained that I could get addicted to them [opioids]."* • *"Need to get in front of the problem through education."* • *"Addiction affects the entire family, not just the individual. Family needs to know how to cope and react. They need to know there are other supports."* • *"Opioid misuse and abuse generally follows a cascade of unmet needs. Whether it be basic needs (food, housing etc.) or physical needs (uncontrolled pain, depression and mental health concerns, comorbid substance abuse) identifying the root cause and developing strategies for preventing these unmet needs. Appropriate prescribing patterns, education, disposal, and community support are needed to ensure safe use of opioids in our community."*
Ease of getting prescription opioids
• *"When I got addicted, it was largely due to prescriptions. I could call whenever and get 100 pills."* • *"After my hysterectomy, I called 4 different doctors and got refills from every single one."*

• *"It's easy to doctor shop."*
Stigma: Lack of dignity for people who use drugs and people living in poverty
• *"I didn't want to become an addict."* • *"If I had known I was worth it, I could've quit a lot sooner."*
Treatment/Harm Reduction
Education on treatment resources
• *"People don't know the options of what's out there."* • *"Need to get messaging out to people about resources."*
Naloxone: Increase availability to individuals, family members, friends, and organizations
• *"Narcan wasn't carried by the law enforcement agency that responded to my overdose. The doctors told me they weren't sure how I survived."* • *"My friend OD'd right in front of me, and I didn't know what to do. We were both on probation and didn't want to call the cops."*
Follow up to overdose
• *"It's scary to ask for help. A warm hand off would help ease into it."*
Medication Assisted Treatment (MAT)
• Access to MAT in the community is limited – few providers • Doctors in residency program do receive training on MAT, but still don't always prescribe
Treatment: Options are lacking & financial barriers
• *"A lot of people make the decision 'I'm ready', but then can't get in. It's very hard to ask for help."* • *"If you had private insurance, they could get you in that day; if you had state insurance you had to wait several days."* • *"A lot of these people are coming off the streets and barely getting by already; so, when they make the decision to get help it's not because they saved up enough money."*
Recovery
Education on recovery
• *"People think, 'if we get them through the withdrawals, they'll be fine', but there is so much more behind recovery and addiction in general. If those things aren't addressed, it's just a revolving door."*
Transition from treatment to recovery
• *"After treatment, there was nowhere for me to go, I was just let back onto the street."* • *"It's this awful hamster wheel of someone getting addicted, maybe they get treatment, but after treatment they end up back in the same situations and environments and start using. They're not getting the resources to get help."* • *"They took me back to the homeless shelter – there was zero after care. They didn't set you up for anything getting out of treatment."*

The Opioid Use Needs Assessment (Attachment 7) document contains a summary of both the quantitative and qualitative data collected for this strategic planning process.

Steering Committee Meeting: November 2023

In November, the Steering Committee used the Opioid Use Needs Assessment to discuss the status of the core strategies within the community (if they exist, are they consistently implemented, etc.). For a majority of the core strategies, it was determined that the service or resource exists in the community but may not be common or consistently implemented. Following this discussion, the Core Team reached out to additional individuals and groups to gather input on questions the Steering Committee had on specific strategies. Providers working with the pregnant and postpartum population did not perceive opioid use as a significant issue among this population. Providers with experience working in local emergency departments were asked about protocols or procedures for treating patients who had overdosed on opioids. Providers indicated that patients would be medically stabilized, but there was no formal procedure for connecting the individual to resources or services when discharged.

Steering Committee Meeting: January 2024

In January 2024, the Core Team provided a recap of the strategic planning process, data collected during the needs assessment, and lead Steering Committee members through a prioritization process utilizing two group decision-making tools. The first was a Prioritization Criteria Matrix (Attachment 8) where committee members voted on several criteria in a series of polls for each core strategy:

Criteria	***Value***
Cost	High, Low
Ease of Implementation	Hard, Easy
Impact	Program-level, System-level
Expand/Enhance	Yes, No
Community Impact	High, Low

Response options were assigned a score of 1 or 5 and cumulative scores were shared with participants in real time. Based on the scores, six of the eight strategies were moved onto the next tool, an Eisenhower Matrix (Attachment 9). In this exercise, the committee members ranked each strategy on sliding scales (0-10) for partner buy-in (high or low) and timeline for implementation (quick or long-term).
The six strategies voted on included:

1. Broaden access to naloxone & #8. Expand harm reduction services
2. Increase use of medications to treat opioid use disorder
5. Fund warm hand-off programs and recovery services
6. Improve treatment in jails and prisons
7. Enrich evidence-based prevention strategies
9. Support data collection and research

After voting utilizing two sets of criteria, the group utilized the resulting placement of each strategy in the Eisenhower Matrix to inform discussion and decision-making on the initial strategies for implementation to be included in the recommendations to the Board of Supervisors.

The Steering Committee provided potential partners to reach out to for further input on the feasibility of implementing the prioritized strategies. Core Team members met with these partners in February 2024 to gather more details before presenting recommendations to the Board of Supervisors. Based off the prioritization results from the Steering Committee and the identification of partners who were willing to assist with implementation, the two strategies recommended for initial use of funds include:

Core Strategy #5	Fund warm hand-off programs and recovery services
Core Strategy #7	Enrich evidence-based prevention strategies

Steering Committee Recommendations to Board of Supervisors

Core Strategy #5: Fund warm hand-off programs and recovery services

The settlement recommends jurisdictions expand services, such as warm hand-offs and care coordination, to assist individuals in receiving treatment and support services. For individuals struggling with substance use, transitions between care and connections to needed resources can be very challenging to navigate. This was a major theme of the focus groups conducted with persons with lived experience. Following a non-fatal overdose, release from jail, or the completion of a substance use treatment program, individuals were released back into the same environments without any referrals to resources or care. Enhancing systems to link individuals to a variety of services (housing, treatment, employment assistance, support groups, peer counselors, etc.) at these connection points could result in more holistic care and improved overall outcomes for this population. Some care coordination programs and positions already exist in the community, therefore the Core Team will be working with Steering Committee partners to expand and enhance these services to broaden the reach to individuals struggling with substance use.

Core Strategy #7: Enrich evidence-based prevention strategies

Prevention strategies recommended by the settlement included the funding of media campaigns, youth primary prevention programs, and medical provider to prevent the misuse of prescription drugs. There is a strong evidence base for youth primary prevention programs, which have been shown to reduce risky behaviors, including drug misuse. These programs focus on promoting positive youth development and preventing risk factors for both substance use and mental health issues. Focus group feedback from multiple populations emphasized the importance of preventing issues before they develop through education. Utilizing resources from the Blueprints for Healthy Youth Development Registry and the Evidence-Based Practices Resource Center from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Core Team will be working with local school districts to implement this strategy.

Next Steps: Planning, Implementation, & Evaluation

Measures to monitor progress and outcomes for each strategy will be developed in collaboration with implementation partners as part of the contracting process and based upon evidence-based or best practices.

Members of the Opioid Settlement Steering Committee will continue to be updated on the progress of strategies throughout implementation and evaluation. The Steering Committee will be assembled once a year, at minimum, to discuss the progress of the implemented strategies and discuss any opportunities to improve efforts. Keeping the Steering Committee engaged will assist in sustainable continuation of this strategic planning process in future cycles.

The Iowa Attorney General requires a Public Annual Report be submitted on December 1 of each year. A summary of funded activities, amount of funds expended, and progress and/or outcomes of funded activities will be included. An annual update will be provided to the Scott County Board of Supervisors as well.

To best respond to the needs of the community, this strategic planning process will be completed again to evaluate current data, trends, resources, and gaps in addressing the opioid crisis in Scott County. It is anticipated that this will occur in three-to-five-year iterations based upon a variety of factors including: community resources, policy changes, data trends, evaluation of programs and performance measures, etc.

References

1. Johns Hopkins Bloomberg School of Public Health – Primer on Spending Funds from the Opioid Litigation: https://opioidprinciples.jhsph.edu
2. Johns Hopkins Bloomberg School of Public Health – Principles for the Use of Funds from the Opioid Litigation: https://opioidprinciples.jhsph.edu
3. Iowa Public Health Tracking Portal: https://tracking.idph.iowa.gov/Health
4. Centers for Disease Control and Prevention – Understanding the Opioid Epidemic: https://www.cdc.gov/opioids/basics/epidemic.html

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

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

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

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

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

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

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

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

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

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

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

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

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

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

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

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

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

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

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

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

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

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

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

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

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

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

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

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

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

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

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

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

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

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

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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

Primer on Spending Funds from the Opioid Litigation

A Guide for State and Local Decision Makers

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Executive Summary

States and local jurisdictions face difficult decisions about spending the dollars they will receive as part of litigation against opioid manufacturers, distributors, pharmacies, and other entities.

This document is intended to help jurisdictions identify evidence-based programs to fund with the money. It provides background information on each of the nine core abatement strategies described in the settlement agreements with opioid distributors and the opioid manufacturer Johnson & Johnson.

These nine core abatement strategies[1] are:

- Broaden access to naloxone
- Increase use of medications to treat opioid use disorder
- Provide treatment and supports during pregnancy and the postpartum period
- Expand services for neonatal opioid withdrawal syndrome
- Fund warm hand-off programs and recovery services
- Improve treatment in jails and prisons
- Enrich prevention strategies
- Expand harm reduction programs
- Support data collection and research

By investing in evidence-based programs and services that address areas of need, communities can save lives and address the toll of the opioid epidemic.

Contents

[1] Some of the section headings have been altered from the settlement agreements for clarity and to reflect updated language. For example, while the settlement agreements use the term medication-assisted treatment, medications for opioid use disorder is preferred because it more accurately characterizes medication as an appropriate stand-alone treatment, not merely an addition to other forms of treatment.

Background

Over 100,000 people died as a result of the overdose epidemic from September 2020 to September 2021. Approximately 75,000 of those deaths involved opioids, most of which were due to synthetic opioids such as fentanyl. Spending the litigation money on strategies shown to save lives from prescription opioid misuse and illicit opioid use is essential.

The settlements with Johnson & Johnson and three opioid distributors outline nine core abatement strategies, described in Exhibit E of the settlements, to address the opioid crisis. The settlements encourage states and localities to choose projects that are part of these nine strategies, although jurisdictions are given significant discretion in how they spend the funds. Selecting programs in these areas, however, is not sufficient to make sure that the dollars have the greatest impact. Jurisdictions must be sure that the programs that they are funding are supported by evidence and that they are filling areas of need. This document lays out some of the considerations that jurisdictions should use in making these decisions.

Given the short-term nature of the funds (payments will be made over 18 years, though they will be larger in the early years), jurisdictions should prioritize funding projects in need of one-time or start-up costs. Organizations that receive funds to help with operating expenses should have a plan in place to ensure sustainability. Additionally, jurisdictions should avoid using the dollars in areas where other funds are available. For example, Medicaid and other insurance programs should be used as a payment source for treatment wherever possible instead of relying on litigation dollars.

Jurisdictions looking for more information on evidence-based strategies that they should implement can turn to a number of sources for more details, including:

- *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic*;
- *From the War on Drugs to Harm Reduction: Imagining a Just Response to the Overdose Crisis*;
- The Brandeis Opioid Resource Connector;
- Curated Library about Opioid Use for Decision-makers (CLOUD); and
- Substance Abuse and Mental Health Services Administration's Evidence-Based Practices Resource Center.

The approach in this document is based on the *Principles for the Use of Funds From the Opioid Litigation*, which have been endorsed by over 50 organizations. Jurisdictions can also see *Ten Indicators to Assess the Readiness of State and Local Governments to Receive the Opioid Settlement Funds* for additional ideas for how to prepare for effective use of the money.

Core Strategy 1

Broaden access to naloxone

The settlements state that funds from the litigation should be used to increase the availability of naloxone—a medication approved by the FDA to reverse opioid overdoses—particularly among vulnerable groups who may be uninsured or underinsured. The settlements also suggest expanding naloxone distribution and training for first responders, schools, community support groups, and families. A deep evidence base supports using funds to expand access to naloxone.

What is evidence around the use of naloxone?

Approximately 40% of overdose deaths happen with someone else present; increasing the availability of naloxone among those who use drugs and the community as a whole has the potential to dramatically decrease the number of opioid overdose deaths. Background information about naloxone can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website.

Numerous studies have found that increasing the distribution of naloxone in the community is associated with fewer overdose deaths. A summary of the evidence can be found in *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic* (Chapter 3) and *From the War on Drugs to Harm Reduction: Imagining a Just Response to the Overdose Crisis* (Recommendation 2).

The out-of-pocket cost of naloxone can range from $30 to $100 or more, which can be a barrier to its use.

Who should carry naloxone?

The surgeon general has recommended that people at risk of opioid overdose, friends and family of people with an opioid use disorder, and community members who come into contact with people at risk for an opioid overdose should all carry naloxone. Given the current shortage of naloxone in many areas, naloxone programs may need to prioritize distribution to high-priority groups. Due to racial disparities in access to naloxone, wider distribution of naloxone in communities of color may help address the increasing overdose rate in those communities.

How important are naloxone trainings?

Communities should provide trainings on the use of naloxone available so that health professionals and lay people are comfortable administering the medication. These trainings should be as widely available as possible, including online, so that uncertainty about how to administer naloxone does not impede its use. Trainings can also be an opportunity to dispel myths around naloxone, such as that the presence of naloxone encourages people to use more drugs. However, training should not be required to pick up naloxone, so as not to create unnecessary barriers.

How can jurisdictions use litigation money to increase access to naloxone?

Jurisdictions should increase the supply of naloxone in the community by:

- Buying it in bulk and distributing it themselves;
- Coordinating purchases with other communities in order to negotiate a better price; and
- Providing financial support to community-based organizations for naloxone distribution, including start-up costs and bulk purchasing of naloxone.

Additionally, jurisdictions could use the funds to provide trainings on the use of naloxone and for communication campaigns around the use and availability of the medication.

Core Strategy 2

Increase use of medications to treat opioid use disorder

The settlements state that funds should be used to:

- Increase the use of medications to treat people with opioid use disorders;
- Provide education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
- Increase treatment options such as residential or inpatient treatment, outpatient treatment, therapy, counseling, and recovery housing.

Medications—methadone, buprenorphine, and naloxone—are the gold standard for opioid use disorder treatment, with extensive evidence proving their effectiveness. Given the low uptake of these medications, jurisdictions should prioritize the development and support of programs that will expand access, particularly for historically marginalized populations that do not currently have access.

What are the medications used to treat opioid use disorder?

The most effective treatments for people with an opioid use disorder are buprenorphine and methadone; they reduce cravings and withdrawal symptoms, and have been shown to decrease the risk of overdose death by 50%. Naltrexone has also been approved to treat an opioid use disorder, but patients must not have used opioids for at least seven days prior to initiating naltrexone. All three types of medication should be available to all individuals with an opioid use disorder; people should be able to work with their care team to determine the best fit.

Unfortunately, just 11% of all individuals with an opioid use disorder receive one of these medications. A consensus study report, *Medications for Opioid Use Disorder Save Lives*, by the National Academies of Sciences, Engineering, and Medicine, contains detailed information on the value of these medications.

What other services help people in treatment and recovery?

There is no one-size-fits-all treatment for opioid use disorder; treatment strategies should be individualized and could also include approaches such as cognitive behavioral therapy and other forms of counseling, 12-step programs, and community support groups.

Other holistic recovery supports include housing, transportation, case management, childcare, employment assistance, support groups, and peer support specialists. Studies have shown that individuals who receive additional supports in conjunction with medication for the treatment of their opioid use disorder are more likely to continue treatment. These services are an integral and evidence-based component of treatment (see p. 19 of *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic* for more information).

How can people receive medication for the treatment of opioid use disorder?

Health systems should make it as easy as possible for people to start taking one of the medications; this is known as low-threshold treatment. In particular, starting buprenorphine in emergency departments is supported by numerous studies. Other examples of low-threshold treatment include prescribing buprenorphine upon a patient's first outpatient visit, over telemedicine, and at mobile treatment locations. An Issue Brief from the University of Pennsylvania summarizes the evidence for such low-threshold treatment.

Methadone must be dispensed by an approved opioid treatment program where patients typically must show up each day for their medication, or via mobile units. During the pandemic, methadone facilities provided expanded take-home methadone access. Buprenorphine can be prescribed by outpatient providers and picked up at pharmacies. Naltrexone is typically given as an injection but is not commonly used outside of correctional settings because of the abstinence requirements for initiation and adherence challenges.

Chapter 2 of *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic* describes additional elements of effective medication treatment programs. These include:

- *Team-based primary care*, in which the primary care physician serves as a care coordinator for a team of clinical and community support providers. Collaborative Care models represent one form of team-based primary care with evidence for opioid use disorder treatment; and
- *Hospital-to-primary care linkages*, which connect patients seen in hospitals for overdose to primary care providers.

How can jurisdictions use litigation money to improve treatment options?

Jurisdictions should fund programs that:

- **Provide low-threshold access to medication treatment including: buprenorphine prescriptions in emergency departments, upon first outpatient visit, over telemedicine, at mobile treatment locations, and for uninsured individuals;**
- **Use care linkages including team-based primary care and hospital-primary care linkages. These treatment models are often in need of one-time start-up costs to aid in their adoption;**
- **Provide holistic recovery supports such as housing, case management, transportation, childcare, employment assistance, support groups, and peer counselors.**

Additionally, jurisdictions should not fund programs that prohibit people from being on one of these medications.

Core Strategy 3

Provide treatment and supports during pregnancy and the postpartum period

The settlement agreements recommend using funds from the litigation to expand the range of programs and services available to treat opioid use disorder during pregnancy and the postpartum period (at least the first 12 months after birth).

What is evidence-based care during pregnancy and the postpartum period?

Treatment during pregnancy and the postpartum period is similar to treatment for people who are not pregnant; use of buprenorphine or methadone is the evidence-based standard of care. Team-based care and holistic recovery supports are also important. The Centers for Disease Control and Prevention (CDC) provides an overview of evidence-based treatment during pregnancy and the postpartum period.

Particular considerations for OUD treatment during pregnancy include:

- While infants may develop neonatal opioid withdrawal syndrome (see Core Strategy 4) from buprenorphine and methadone as with other opioids, medications improve outcomes for both parents and their children by mitigating the risk of relapse, overdose, and other severe impacts associated with untreated OUD.
- The treatment plan should be tailored by a team that includes both an addiction treatment provider and an obstetrician. Note that Collaborative Care models of treatment have been shown to be feasible for treatment of opioid use disorder during pregnancy and the postpartum period.
- Holistic treatment and recovery supports for pregnancy and the postpartum period include home-visiting programs, child care, parenting support, family-centered care models, and programs that help families stay together.

The National Center on Substance Abuse and Child Welfare hosts a resource center, and the National Harm Reduction Coalition and the Academy of Perinatal Harm Reduction offer an implementation toolkit with additional information on improving care for people who use drugs during pregnancy.

What barriers are there to accessing treatment during pregnancy and the postpartum period?

Due in part to stigma, it can be difficult to find a treatment provider during pregnancy and the postpartum period; a 2020 study found that people were 17% less likely to be accepted to buprenorphine treatment while pregnant. Additionally, in some states people on Medicaid, which paid for 42% of births in 2020, lose coverage 60 days after giving birth.[2]

[2] With the passage of the American Rescue Plan, states can now keep people on Medicaid for 12 months after they give birth.

How should jurisdictions use litigation money to improve treatment options during pregnancy and the postpartum period?

Jurisdictions should fund programs that:

- Offer free or low-cost methadone and buprenorphine treatment and counseling during and after pregnancy in primary care and reproductive health settings;
- Fund anti-stigma campaigns and education to reduce barriers to MOUD treatment for pregnant and postpartum people;
- Fund one-time start-up costs for providers to use models such as Collaborative Care;
- Provide comprehensive supports, including case management, childcare, transportation, employment assistance, family housing and family-centered treatment, support groups, referral services, and peer counselors as described in this publication by the National Academy for State Health Policy; and
- Provide home visiting programs to support families after birth (post-birth family support programs are discussed in more detail in Core Strategy 4).

While the settlement agreements recommend funding an approach during pregnancy known as Screening, Brief Intervention, and Referral to Treatment (SBIRT), this program has not been proven to work for opioid use disorders. Accordingly, it should only be funded through pilot programs that also include other evidence-based strategies and research to examine its effectiveness.

Core Strategy 4

Expand services for neonatal opioid withdrawal syndrome

The settlement agreements suggest expanding treatment and services for infants who have signs of withdrawal from opioids that they have been exposed to before birth, a condition known as neonatal opioid withdrawal syndrome. Improving outcomes for these children and their families relies upon hospitals to provide peripartum care with evidence-based models, while public health systems deliver family and parenting supports during and after pregnancy.

What are the impacts of neonatal opioid withdrawal syndrome?

According to one analysis, around seven out of every 1,000 infants in 2017 needed additional care as a result of prenatal exposure to opioids. Detailed information can be found on the websites of the March of Dimes and the Substance Abuse and Mental Health Services Administration.

Despite its prevalence, a recent expert review states: "*A diagnosis of [neonatal opioid withdrawal syndrome] does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.*"

Many children with in utero opioid exposure have normal development and are able to succeed in their education and careers. The purpose of supportive services for neonatal opioid withdrawal syndrome is to help these children and their families reach their potential.

What should health systems do?

If they have not already, health systems should implement evidence-based approaches to care for infants exposed to opioids and their families. The American Academy of Pediatrics' clinical report on the topic states that the preferred model of care in the hospital keeps the parents and baby together (referred to as "rooming-in") while the infant is being evaluated and treated as necessary. This approach is associated with lower rates of medication treatment and shorter hospital stays. It may also promote bonding and facilitate breastfeeding. A description of this approach can be found in this article from the National Institute for Children's Health Quality.

What long-term services should infants exposed to opioids in utero receive?

The American Academy of Pediatrics recommends that all infants with prenatal substance use exposure be referred to early intervention services and developmental assessments as needed. The Health Resources and Services Administration's guide on home visiting programs outlines additional services that may be beneficial for families.

How should jurisdictions use litigation money to expand treatment for neonatal abstinence syndrome?

Jurisdictions should assist hospitals that have not yet implemented rooming-in protocols and other evidence-based clinical guidelines for the care of newborns with prenatal exposure to opioids and their families.

Additionally, jurisdictions should fund programs as laid out in Chapter 5 of Evidence Based Strategies for the Abatement of Harms from the Opioid Epidemic, including:

- Programs that integrate evidence-based treatment for opioid use disorders with health and family services;
- Home visiting programs, such as the Nurse-Family Partnership and Child First;
- Family skills training interventions, such as the Strengthening Families Program and Families Facing the Future; and
- Early intervention programs.

Core Strategy 5

Fund warm hand-off programs and recovery services

The settlement recommends that jurisdictions fund the expansion of services to help individuals navigate their recovery journey. Warm hand-offs and coordinated care use person-centered services such as peer navigators to help them successfully start receiving treatment and support services, including:

- Beginning medications for the treatment of opioid use disorder;
- Transitioning to a residential recovery facility;
- Receiving support for co-occurring substance use and mental health conditions; and
- Getting recovery support services like housing, transportation, job placement, and childcare.

Holistic recovery support services have a rich evidence base supporting their use (see, for example, p. 19 of Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic) and help individuals establish the four important pillars of recovery: health, home, purpose, and community.

How do warm hand-offs work?

Transfers of care are frequent and challenging for people with substance use disorders. For example, someone who has been seen for emergency care services by first responders or emergency departments following a non-fatal overdose may be referred to a primary care provider for medication treatment and a behavioral health specialist. Someone leaving a correctional facility and re-entering the community may be linked to nearby treatment services and other community-based supports.

Who can benefit from warm hand-offs?

Warm hand-off programs often focus on particularly vulnerable groups of people who use drugs. These can include people who:

- Have co-occurring substance use disorder and behavioral health needs (over 40% of individuals in SUD treatment also have a mental health disorder);
- Face structural vulnerabilities, like socioeconomic status, geography, insurance status, and housing insecurity—some studies show that SUD prevalence among homeless populations can exceed 50%;
- Have had criminal justice involvement (some estimates indicate that one-third of criminal justice involved individuals have an OUD); and
- Are pregnant or postpartum (see Core Strategy 3).

Organizations where coordinated care is particularly important include: hospitals, primary care providers, first responders, community based treatment and harm reduction service providers, behavioral health centers, and correctional facilities. Chapter 2, Sections 2.4-2.8, of *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic* outlines the evidence of using coordinated care to improve outcomes for individuals with OUD. Additionally, Pennsylvania has developed detailed resources on warm hand-offs.

How should jurisdictions use litigation money to improve warm hand-off programs and recovery supports?

Jurisdictions should fund:

- The expansion of existing warm hand-off programs or start-up costs for new programs that explicitly connect clients to a variety of services; and
- Organizations that provide treatment and holistic recovery supports such as housing, case management, childcare, employment assistance, support groups, peer counselors, and recovery coaches.

Core Strategy 6

Improve treatment in jails and prisons

The settlement agreements recommend that jurisdictions support individuals involved in the criminal justice system who also have opioid use disorder by using funds to increase access to evidence-based treatments and recovery supports while incarcerated.

The Department of Justice has recently released guidance for treating individuals with opioid use disorder. The statement aligns with recent legal decisions that failing to offer treatment to incarcerated people with opioid use disorder is discriminatory under the Americans with Disabilities Act, and denying access to medications for the treatment of opioid use disorder (methadone, buprenorphine, and naltrexone) violates the Eighth Amendment to the U.S. Constitution, which prohibits "cruel and unusual punishment." Correctional facilities should increase their ability to provide MOUD to ensure compliance with federal antidiscrimination laws.

What services should jails and prisons provide to people with an opioid use disorder?

More than half of individuals in prison and two-thirds of people in jails have a substance use disorder. Rates of overdose deaths are very high after release from a correctional facility. Starting treatment with methadone or buprenorphine while people with an opioid use disorder are still incarcerated has been shown to reduce overdose deaths and illicit opioid use. Unfortunately, few jails and prisons offer one of these medications to people who are incarcerated. Behavioral therapies may also be helpful in addition to treatment with medication.

Chapter 4 of *Evidence Based Strategies for the Abatement of Harms from the Opioid Epidemic* contains detailed information about care for people with opioid use disorders in the criminal justice system.

How are these programs administered?

This toolkit provides a detailed guide on the development and implementation of programs to deliver medications in correctional settings to people with an opioid use disorder. It includes sections on preparing for change, program planning and design, workforce development and capacity, delivery of treatment, linkages to care and services upon release, data monitoring and evaluation, and funding and sustainability. The Jail & Prison Opioid Project provides additional details and resources on this topic.

What about diversion concerns?

The misuse, illicit use, or diversion of methadone and buprenorphine among people who are incarcerated is often cited as a concern for jails and prisons. Generally, diversion indicates inadequate access to treatment. There is little evidence of legitimate disruption caused by diversion within criminal legal settings.

What about programs that provide alternatives to incarceration?

Some programs seek to address the underlying substance disorder that led to a crime by providing a range of services instead of incarceration for people with substance use disorders. Such programs can be particularly important as part of efforts to address inequities in incarceration rates, given that people of color are more likely to be arrested as a result of their drug use.

This overview from the National Council for Mental Wellbeing provides details on the effectiveness and core components of these programs. For example, the Law Enforcement Assisted Diversion program, used in Washington's King County and other jurisdictions, has shown benefits across a range of outcomes, including recidivism, housing, and employment.

How can jurisdictions use litigation money to improve treatment options for people in the criminal legal system?

Jurisdictions should use funds to start and expand programs that offer treatment to incarcerated people with all three forms of medication for opioid use disorder (methadone, buprenorphine, and naltrexone) and connect them with community-based treatment upon reentry. Detailed case studies on how the Pennsylvania and Vermont Departments of Corrections, the Denver City and County jails, and the Middlesex (MA) Jail and House of Corrections have provided treatment can be found here.

Additionally, jurisdictions should fund evidence-based programs that connect people to behavioral health services and supports as an alternative to incarceration.

Core Strategy 7

Enrich prevention strategies

The settlement agreement recommend a number of interventions to prevent people from developing an opioid use disorder, including the funding of: media campaigns; school-based prevention programs; and medical provider education to prevent youth and other individuals from misusing prescription drugs.

The settlement also recommends funding community drug disposal programs, although there is no research demonstrating the effectiveness of these programs. Given the lack of evidence supporting many prevention interventions, we recommend a focus on evidence-based youth primary prevention programs that have been shown to reduce risky behaviors, including drug misuse.

What are the components of evidence-based youth primary prevention programs?

Preventing future opioid misuse is essential to curbing the opioid and overdose epidemic. As presented in a recent overview, when selecting and implementing youth primary prevention programs, jurisdictions should look for programs that include the following components:

- *Delivered across childhood and adolescence in a coordinated fashion.*
- *Aimed at promoting positive youth development and preventing risk factors for both substance use and mental health problems.*
- *Implemented in settings that serve youth, including schools and a range of youth-serving organizations.*
- *Delivered in a tiered fashion whenever possible.*
- *Inclusive of parents and other caregivers.*
- *Implemented in a way that is trauma informed, culturally sensitive, and equitable.*

How should jurisdictions use litigation money to improve prevention programs?

Jurisdictions should fund evidence-based school- and community-based youth primary prevention programs, with a focus on equitable distribution of resources. The following websites compile examples of such programs:

- **Blueprints for Healthy Youth Development**
- **The Evidence-Based Practices Resource Center from the Substance Abuse and Mental Health Services Administration**
- **The Program Directory Search at Youth.gov**

Jurisdictions should be wary of funding prevention programs that do not have evidence supporting their use, such as community drug disposal programs, but should consider investments in promising programs not included in the above lists if they meet predetermined parameters of quality and fidelity with substance use prevention and mental health promotion science. Cultural relevance should be considered when selecting prevention programs, and youth, families, and other community stakeholders should help guide intervention selection and implementation.

Core Strategy 8

Expand harm reduction programs

The settlement agreements recommend funding comprehensive syringe services programs, an integral part of a comprehensive strategy known as harm reduction. Jurisdictions should expand not only syringe services, but also other harm reduction programs that can deliver services such as linkage to treatment, access to safer drug use supplies, and other medical support services.

How do syringe services programs help address the opioid epidemic?

Effective syringe services programs provide sterile syringes and other supplies to people who are injecting drugs to prevent them from getting blood-borne infections such as HIV and hepatitis C. Additionally, these programs can implement additional public health strategies, including naloxone and connections to treatment, medical care, housing, and other social services.

What are other evidence-based harm reduction services?

In addition to syringe services programs, other evidence-based harm reduction services include providing supplies for safer consumption of drugs, naloxone, fentanyl test strips, and overdose prevention sites. Chapter 3 of *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic* outlines evidence for these programs.

What are some important considerations when developing effective syringe services programs?

Engaging affected communities ahead of time is critical in launching or expanding syringe services programs and other harm reduction services, as described in Recommendation 3 from *From the War on Drugs to Harm Reduction: Imagining a Just Response to the Overdose Crisis*.

Other information, trainings, and guides can be found through the National Harm Reduction Coalition, including information on how to address stigma surrounding harm reduction programs.

How can jurisdictions use litigation money to improve harm reduction programs?

In addition to using funds to support syringe services programs, jurisdictions should consider using litigation dollars to support areas of harm reduction that may be limited by other funding regulations. These include:

- **Needles, syringes, and other safer drug-use supplies;**
- **Fentanyl test strips; and**
- **Overdose prevention sites as outlined in Chapter 3 of Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic.**

Additionally, jurisdictions should consider funding other harm reduction programs related to injection drug use such as HIV and hepatitis C education.

Core Strategy 9

Support data collection and research

Finally, the settlement agreements recommend that jurisdictions fund ongoing data collection and research in order to make sure that the abatement strategies receiving support are working.

Why is data collection and program evaluation important?

Without effective data surveillance, jurisdictions can't determine if the strategies they are using to address the opioid crisis are working and whether new approaches are needed. Data collection is also essential to health equity: smaller populations such as American Indians and Alaska Natives are often left out of health tracking, leading to lack of representation and consideration in service planning and allocation.

Data on access to and quality of treatment services helps individuals find appropriate treatment. For example, several states have partnered with Shatterproof to offer the Addiction Treatment Locator, Assessment, and Standards Platform (ATLAS). Additionally, jurisdictions should plan and fund program evaluation to ensure that specific programs are working as intended, especially when they are being used in different populations or groups than originally studied. State and local governments may be able to take advantage of the research expertise and outside perspective of research institutions and consultants to help with program evaluation. The Bloomberg American Health Initiative's Quick Guide to Successful Data Partnerships presents additional examples of data partnerships.

How should jurisdictions use litigation money to obtain accurate data that informs effective and equitable program monitoring and development?

Jurisdictions should fund:

- Evaluations of abatement programs with metrics that are in line with the overall goals of the jurisdiction, such as nonfatal overdose, infectious disease rates, and naloxone administration;
- Collection of data on the availability and quality of treatment programs, support services, and harm reduction services;
- Workforce development, data dashboard start-up, and other initiatives that promote sustainable long-term monitoring; and
- Projects designed to collect data in smaller populations. This requires creating equal partnerships with communities to identify appropriate data collection strategies, particularly when working with indigenous communities.

Principles for the Use of Funds From the Opioid Litigation

Principles for the Use of Funds From the Opioid Litigation

States, cities, counties, and tribes will soon be receiving funds from opioid manufacturers, pharmaceutical distributors, and pharmacies as a result of litigation brought against these companies for their role in the opioid epidemic that has claimed more than half a million lives over the past two decades.

Governors, attorneys general, and legislators will face difficult decisions in determining the best use of these funds. We support the following principles:

1. **Spend money to save lives.**
   Given the economic downturn, many states and localities will be tempted to use the dollars to fill holes in their budgets rather than expand needed programs. Jurisdictions should use the funds to supplement rather than replace existing spending.

2. **Use evidence to guide spending.**
   At this point in the overdose epidemic, researchers and clinicians have built a substantial body of evidence demonstrating what works and what does not. States and localities should use this information to make funding decisions.

3. **Invest in youth prevention.**
   States and localities should support children, youth, and families by making long-term investments in effective programs and strategies for community change.

4. **Focus on racial equity.**
   States and localities should direct significant funds to communities affected by years of discriminatory policies and now experiencing substantial increases in overdoses.

5. **Develop a fair and transparent process for deciding where to spend the funding.**
   This process should be guided by public health leaders with the active engagement of people and families with lived experience, clinicians, as well as other key groups.

This document describes these principles in greater detail.

Background

Addiction is an ongoing public health crisis in the United States; an estimated 20 million people have a substance use disorder related to alcohol or illicit drugs. Recent attention has understandably focused on the role of opioids—which have killed more than 500,000 people over the past two decades. Driven in large part by increases in overdose deaths and suicides (which are often associated with substance misuse), life expectancy in the United States dropped from 2014 to 2017, the first three-year decline in nearly a century.

Already dire, the situation has worsened with the COVID-19 pandemic. The economic downturn and social distancing mandates have increased the chance of overdose among people who use drugs. Preliminary data indicate that overdose deaths have increased in most states compared to a year ago, with some states reporting an estimated 30% increase in opioid-related deaths so far in 2020. Early evidence also indicates a significant increase in alcohol consumption, anxiety, and depression during the pandemic. Accordingly, addressing mental health and addiction should be part of any COVID-19 response.

Confronting this new crisis, many localities are already adopting interventions that save lives. Fortunately, new financial resources that can help states and communities fund additional programs are close at hand as a result of lawsuits brought by States, cities, counties, and tribes against opioid manufacturers, pharmaceutical distributors, and pharmacies. This is an unprecedented opportunity to invest in solutions to address the needs of people with substance use disorders.

For this to happen, jurisdictions must avoid what happened with the dollars that states received as part of the litigation against tobacco companies. Those landmark lawsuits were hailed as an opportunity to help current smokers quit and prevent children from starting to smoke. Unfortunately, most states have not used the dollars to fund tobacco prevention and cessation programs. Overall, less than 3% of revenue from the settlement and tobacco taxes went to tobacco control efforts. Failure to invest these dollars in tobacco prevention and cessation programs has been a significant missed opportunity to address the greatest cause of preventable death in the United States.

To guide jurisdictions in the use of these funds, we encourage the adoption of five guiding principles through specific actions outlined here. The principles are as follows:

1. **Spend money to save lives.**
2. **Use evidence to guide spending.**
3. **Invest in youth prevention.**
4. **Focus on racial equity.**
5. **Develop a transparent, inclusive decision-making process.**

Principle 1: Spend money to save lives.

Given the economic downturn, many states and localities will be tempted to use the dollars to fill holes in their budgets rather than expand needed programs. Jurisdictions should use the funds to supplement rather than replace existing spending.

In addition to its dramatic health impacts, the COVID-19 pandemic has also harmed the U.S. economy, leaving gaps in localities' operating budgets. Despite the increasing number of overdose deaths, many state and local governments have already made cuts to substance use and behavioral health programs.

However, at current funding levels, these programs are already not meeting the needs of people who use drugs. For example, only an estimated 10% to 20% of people with opioid use disorder are receiving any treatment at all. Accordingly, groups like the American Medical Association and the American Bar Association have called for all settlement funds to address the substance use epidemic.

How can jurisdictions adopt this principle?

1) *Establish a dedicated fund.*
Ensuring that funds from the opioid lawsuits are being used to help people with substance use disorders is easier if dollars resulting from the various legal actions go into a dedicated fund. When establishing such a fund, jurisdictions should include specific language that the money from the fund cannot be used to replace existing state investments and outline the acceptable uses of the dollars when establishing this fund. (See *Principle 2—Use evidence to guide spending* for examples.)

2) *Supplement rather than supplant existing funding.*
In order to be sure that funds are being used to expand programs, jurisdictions should understand their baseline level of spending on substance use disorders, including prevention efforts. This will help ensure that dollars from any legal actions are additive to existing efforts. Most jurisdictions have already developed comprehensive strategic plans focused on opioids; these plans can be used as a starting point for prioritizing new investments.

3) *Don't spend all the money at once.*
Ameliorating the toll of substance use, and addressing the underlying root causes, will require sustained funding by states and localities. Jurisdictions should avoid the temptation to exchange future payments that result from the opioid litigation for an upfront lump sum payment, as happened in many states with dollars from the tobacco settlements. Should the opioid lawsuits result in a lump sum payment to jurisdictions, they should consider establishing an endowment so that the dollars can be used over time.

4) *Report to the public on where the money is going.*
Jurisdictions should publicly report on how funds from opioid litigation are being spent. The expenditures should be categorized such that it is easy to understand the goals of a particular program and the measures that they are using to determine success, such as, for naloxone distribution programs, the amount of naloxone distributed.

Principle 2: Use evidence to guide spending.

At this point in the overdose epidemic, researchers and clinicians have built a substantial body of evidence demonstrating what works and what does not. States and localities should use this information to make funding decisions.

Jurisdictions run the risk of using new dollars on programs that do not work or are even counterproductive if they do not rely on evidence to guide the spending. As one example, people with opioid use disorder in many residential treatment facilities are prohibited from being treated with methadone or buprenorphine, despite evidence that these medications reduce the chance of overdose death by 50% or more. To address this gap, jurisdictions can use the dollars to help residential programs transition to offering a full range of medication treatment options.

How can jurisdictions adopt this principle?

1) *Direct funds to programs supported by evidence.*
   Jurisdictions should fund initiatives demonstrated by research to work and not fund programs shown not to work. Interventions that work, ranging from youth prevention efforts to harm reduction programs to communications campaigns that address stigma, have been compiled by a number of different organizations. See *Appendix 1* for examples of these summaries, which should serve as references as jurisdictions determine which interventions to fund. Additionally, state and local agencies that oversee substance use interventions have significant expertise regarding programs that work.

   Should jurisdictions fund programs that have not been studied, they should also allocate sufficient dollars to confirm their effectiveness.

2) *Remove policies that may block adoption of programs that work.*
   In many jurisdictions, state and local policy change may need to occur in order for affected communities to implement evidence-based models. For example, state restrictions may cap the number of methadone clinics that may operate in the state, may make it difficult for nurse practitioners to prescribe buprenorphine, or may impede good harm reduction practices by banning syringe service programs. States should ensure that their regulations are not more restrictive than federal guidelines.

3) *Build data collection capacity.*
   An important part of determining which programs are working in a given jurisdiction is collecting sufficient data. Jurisdictions should consider using opioid settlement funds to build the capacity of their public health department to collect data and evaluate policies, programs, and strategies designed to address substance use.

   In particular, jurisdictions should be sure that they have sufficient data to ensure that they are meeting the needs of minority populations. Localities should make data available to the public in annual reports and on publicly facing data dashboards.

Principle 3: Invest in youth prevention.

States and localities should support children, youth, and families by making long-term investments in effective programs and strategies for community change.

Any comprehensive effort to reduce the toll of substance use generally—and opioids specifically—must invest in youth primary prevention programs.

- Overdoses among children have increased steadily over the past decade; nearly 8,000 adolescents ages 15–19 died of an opioid overdose between 1999 and 2016.
- Substance use by children often persists into adulthood; approximately one-half of all people with substance use disorders start their substance use before age 14.

Primary prevention efforts—which are designed to stop use before it starts—can interrupt the pathways to addiction and overdose. Youth primary prevention also reduces the risk of substance use and lessens other negative outcomes, including low educational status, under- and unemployment, unintended parenthood, and an increased risk of death from a variety of causes.

Youth prevention programs also have a very favorable return on investment—$18 dollars for every dollar spent by one estimate.

How can jurisdictions adopt this principle

Direct funds to evidence-based interventions.
Youth primary prevention programs address individual risk factors (such as a favorable attitude towards substance use) and strengthen protective factors (such as resiliency); they can also address elements at the family and community levels.

Research demonstrates that not all prevention programs are created equal. While there are many examples of effective prevention programs, investments in ineffective prevention initiatives persist. Jurisdictions should be sure that the programs that they are funding are supported by a solid evidence base.

Numerous compilations of effective youth primary prevention interventions already exist, including the following:

- Blueprints for Healthy Youth Development.
- Facing Addiction in America, the Surgeon General's Report on Alcohol, Drugs, and Health, 2016.

Jurisdictions should also fund long-term evaluations of youth prevention programs to ensure that they are having their desired effect.

Principle 4: Focus on racial equity.

States and localities should direct significant funds to communities affected by years of discriminatory policies and now experiencing substantial increases in overdoses.

Although minority communities experience substance use disorders at similar rates as other racial groups, in recent years the rate of opioid overdose deaths has been increasing more rapidly in Black populations than in white ones. Additionally, historically racist policies and practices have led to a differential impact of the epidemic. In particular, minorities are more likely to face criminal justice involvement for their drug use. Black individuals represent just 5% of people who use drugs, but 29% of those arrested for drug offenses and 33% of those in state prison for drug offenses. Minority groups are also more likely to face barriers in accessing high-quality treatment and recovery support services.

These disparities have contributed to ongoing discrimination as well as racial gaps in socioeconomic status, educational attainment, and employment. Without a focus on racial equity when allocating settlement funds, localities run the risk of continuing a cycle of inequity.

How can jurisdictions adopt this principle?

1) *Invest in communities affected by discriminatory policies.*
   Historical patterns of discrimination will take sustained focus to overcome. Jurisdictions should fund programs in minority communities that will tackle root causes of health disparities and eliminate policies with a discriminatory effect.

2) *Support diversion from arrest and incarceration.*
   Localities should:
   - Elevate and expand diversion programs with strong case management and link participants to community-based services such as housing, employment, and other recovery support services.
   - Fund community-based harm reduction programs that provide support options and referrals to promote health and understanding for people who use drugs
   - Increase equitable access to treatments for opioid use disorder including medications for opioid use disorder.

3) *Fund anti-stigma campaigns.*
   Stigma against people who use drugs is pervasive and frames drug use as a moral failure. This stigmatization may contribute to the use of discriminatory punitive approaches to address the epidemic, particularly among racial minority communities, as opposed to more effective ones grounded in public health. In order to address this, jurisdictions should use funds to support campaigns based in evidence that reduce stigma.

4) *Involve community members in solutions.*
   Jurisdictions should fund programs in minority communities with diverse leadership and staff, and a track record of hiring from the surrounding neighborhood. Programs with a diverse workforce of staff, supervisors, and peers are more likely to provide relatable and effective services.

Principle 5: Develop a fair and transparent process for deciding where to spend the funding.

This process should be guided by public health leaders with the active engagement of people and families with lived experience, as well as other key groups.

How can jurisdictions adopt this principle?

1) *Determine areas of need.*
Jurisdictions should use data to identify areas where additional funds could make the biggest difference. For example, data may show that various groups in the state are not reached by current interventions; or that certain geographic areas would benefit from specific programs such as housing assistance or syringe services programs. Existing strategic plans may contain much of this information.

2) *Receive input from groups that touch different parts of the epidemic to develop the plan.*
Jurisdictions should draw upon public health leaders with expertise in addiction and substance use to guide discussions and determinations around the use of the dollars. They should also include groups with firsthand experience working with youth and people who use drugs—including prevention and treatment providers, law enforcement personnel, recovery community organizations, social service organizations, and others—who have insights into strategies that are working, those that need to be revised, and areas where new investments are needed. Once a jurisdiction has conducted an initial assessment of areas where additional resources would be helpful, it should solicit and integrate broad feedback to design a plan that will meet the needs of the local community.

   Jurisdictions should be sure to include people with lived experience, including those receiving medications as part of their treatment, as part of the decision-making process. The Ryan White Program, which distributes HIV funds to affected communities, demonstrates one way to do this; at least one-third of the members of the community Planning Councils that allocate funds to treatment providers must receive program services themselves.

   In addition to the groups from which a jurisdiction may formally seek input, they should also solicit and use input from the public. This will help raise the profile of the newly developed plan and give those with particular insights—such as families and other members of the recovery community—a chance to weigh in.

3) *Ensure that there is representation that reflects the diversity of affected communities when allocating funds.*
To ensure equitable distribution of funds to communities of color, representation from these communities should be included in the decision-making process. Community representatives, leaders, and residents can help leverage community resources and expertise while giving insights into community needs.

Appendix 1: Compilations of Evidence-Based Interventions

- *From the War on Drugs to Harm Reduction*, FXB Center for Health and Human Rights at Harvard University, December 2020.
- *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic*, Coordinated by Richard Frank, Harvard University, Arnold Ventures, November 2020.
- *Bringing Science to Bear on Opioids*, Association of Schools & Programs of Public Health, November 2019.
- *Opioid Settlement Priorities*, Addiction Solutions Campaign, May 2018.
- *Addressing Access to Care in the Opioid Epidemic and Preventing a Future Recurrence*, American Psychiatric Association, American Society for Addiction Medicine, and other groups, April 2020.
- Substance Abuse and Mental Health Services Administration's Evidence-Based Practices Resource Center.
- Curated Library about Opioid Use for Decision-makers (CLOUD).

For a complete list of resources, visit our website: http://opioidprinciples.jhsph.edu/

Scott County Opioid Settlement Planning

Opioid Data - Analysis

Secondary Data					
Source	**Indicator**	**Level**	**Time Frame**	**Breakdowns**	**Themes**
CDC	Drug overdose deaths	County	February 2020 – June 2022	• Month	• January 2020 – March 2023 • Highest number of drug overdose deaths (42) in May 2022 • Lowest number of drug overdose deaths (20) in January 2021 • Average: 30 deaths/month (avgs: Black Hawk – 16; Johnson – 15; Linn – 41; Polk – 127) • Most frequent: 23 deaths/month The provisional data presented includes reported 12 month-ending provisional counts of death due to drug overdose by the decedent's county of residence and the month in which death occurred.
Iowa HHS (Iowa Youth Survey)	• Students' risk perceptions • Perception of peer acceptance • Ease of access to harmful substances • Drug use in the past 30 days • Perception of parents' attitudes	County	2021	• Grade (6th, 8th, & 11th) • Gender	• Scott County youth use of prescription Rx for non-medical reasons (and other indicators) mirrors Iowa %ages
Iowa HHS	• Opioid-involved deaths	State	2017-2022	• Age • Gender • Race • Ethnicity	Iowa All Drug Overdose ED Visits by Age (2022) • Top 3 age groups: 15-24 (28.6%), 25-34 (15.7%), 35-44 (11.8%), 0-11 (11.3%) Iowa Substance Involved Deaths • 2015 – 2021 • % of deaths related to opioids: decreasing (21% to 18%)

					• % of deaths related to alcohol: remaining steady (Average of 70%) • % of deaths related to psychostimulants: increasing (8% to 14%) Iowa Deaths Involving Opioids: • Highest number of deaths in 2021 and 2020; lowest in 2018 • Highest number of deaths since 2018 in 25-34 age group •
Iowa HHS	• Number of suspected drug overdose emergency department visits	County	2018-2022		• 435 visits in Scott County in 2018, decreased to 326 in 2022 • Scott County: 2nd highest rate in 2022 compared to other large counties in IA (Linn, Johnson, and Blackhawk)
Iowa Harm Reduction Coalition	• Have you had a naloxone kit at any time in the past 3 months? • Where did you get a naloxone kit? • Did you avoid seeking health care in the past twelve months and if so, why?	State	2019		Of people who use drugs (PWUD) that were interviewed: • 52% had a naloxone kit at any time in the past 3 months • Majority reported receiving naloxone kit from needle exchange site (highest), drug treatment (next), pharmacy; doctor, clinic, ER was last • Primary reason respondents aren't seeing their health care provider? Fear of stigma; this barrier was higher than healthcare access (transportation, lack of insurance, lack of money)
Recovery Ecosystem Index Score		County	2023		• Scott County, IA has a recovery ecosystem index score of 3.0 (1 = strongest; 5 = weakest) • Substance use treatment facilities per 10k = 2.3 (lower than Iowa & US) • Buprenorphine providers pre 10k = 4 (lower than Iowa & US) • Average distance to nearest MAT provider = 8 miles

Scott County Opioid Settlement Planning

Prescription Monitoring Program	• Opioid prescriptions • Opiate antagonist prescriptions	State County	2021	• Age • Gender	• Significant increases in opioid antagonist prescriptions by gender from 2020 to 2021 • Patients receiving opioid prescriptions has decreased in 12-17, 25-34, 35-44 age groups; remained somewhat level in 45-54, 55-64, 65-74, and 75+ from 2017-2021 • Scott County prescriptions rate per 10,000 ranks #2 for big counties (Black Hawk, Johnson, Linn, Polk, Scott) but 48 out of 99 for all counties • Scott County opiate antagonist patient prescriptions rate per 10,000 is #5 out of most populated counties ((Black Hawk, Johnson, Linn, Polk, Scott) and 59 out of 99 for Iowa Counties
Iowa's Health Initiative for People Who Use Drugs (HIPWUD)	Number of lives that naloxone kits would save based on distribution location	State	2022		In Iowa, 7,000 naloxone kits would save: • 25 lives if naloxone distribution is prescriber-based • 98 lives in naloxone distribution is pharmacy-initiated • 120 lives if naloxone distribution is community-based programs Fewer than 2,000 naloxone kits were distributed in Iowa in 2021 Naloxone access in Iowa: • Naloxone can only be obtained from a pharmacist (individuals cannot share with others) • Immunity to civil/criminal liabilities is limited for persons dispensing or administering naloxone • Naloxone dispensing is reported to the state prescription drug monitoring program, limiting privacy of individuals Other states have naloxone distribution programs, first responder leave-behind programs

Scott County Opioid Settlement Planning

<table>
<tr><th colspan="6">Locally Collected Data</th></tr>
<tr><th>Source</th><th>Indicator</th><th>Level</th><th>Time Frame</th><th>Breakdowns</th><th>Themes</th></tr>
<tr><td>Medic EMS</td><td>911 calls with Narcan administration</td><td>County</td><td>2009-2022</td><td>Month
IV/IO/IM/Nasal
Age
First Listed Billing ICD-10
Gender
Race</td><td>Annual administration numbers have increased; 134 in 2014; 348 in 2022; impacted by internal procedures
Administration higher in African American community than % of the overall population</td></tr>
<tr><td>Medic EMS</td><td>Law enforcement agencies who carry Narcan</td><td>County</td><td>2023</td><td></td><td>
<table>
<tr><th>Fire</th><th>Police</th><th>Don’t Carry</th></tr>
<tr><td>MEDIC</td><td>Davenport</td><td>Blue Grass PD</td></tr>
<tr><td>Davenport</td><td>Bettendorf</td><td>Eldridge PD</td></tr>
<tr><td>Bettendorf</td><td>Buffalo</td><td>LeClaire PD</td></tr>
<tr><td>Durant, Wheatland, Bennett</td><td>Scott County Sheriff’s</td><td>Princeton PD</td></tr>
<tr><td>Eldridge?</td><td>Scott County Conservation</td><td>Walcott PD</td></tr>
<tr><td>LeClaire?</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>City of Davenport</td><td>Incidents where Narcan was administered</td><td>City</td><td>2020-2023 (through 8/27)</td><td></td><td>Incidents where Narcan was administered
2020 – 52
2021 – 82
2022 – 83 (+4 administered by DPD)
2023 – 75 (+5 administered by DPD)</td></tr>
<tr><td>City of Davenport</td><td>DPD incidents where opioids were noted as present</td><td>City</td><td>2020-2023 (through 7/13)</td><td></td><td>DPD incidents where opioids were noted as present
2020 – 25
2021 – 28
2022 – 20
2023 – 10 (half year)</td></tr>
<tr><td>Genesis Health System</td><td>Opioid-related encounters</td><td>County</td><td>2021-2022</td><td>Age</td><td>Opioid-related encounters highest amongst 66+ population
Most opioid related encounters occur in oldest age categories</td></tr>
</table>

Scott County Opioid Settlement Planning

				• Genesis Location • Encounter Type • Reason for Visit • Diagnosis Code • Diagnosis Description	• Largest number of encounters take place at emergency departments and at GHG Woodlands (Family Practice location?)
UnityPoint Health	Opioid-related encounters	County	2021-2022	• Age • Genesis Location • Reason for Visit • Encounter diagnosis • Diagnosis description	• Opioid-related encounters highest amongst 25-30 age group, followed by 31-35 and 66+ • Opioid encounters were most frequently an emergency visit (between 600-650 encounters in 2021-2022) vs. office visit 1 or 2 concerns (between 200-225 encounters in 2021-2022); encounters of these types were relatively similar for
Vera French	Patients with OUD		2021-2023	• Count by year	Patients with Opioid Use Disorder • 2021: 151 • 2022: 176 • 2023: 156* *not total year*
Iowa Harm Reduction Quad Cities	• Overdose reversals Naloxone kits dispensed	Quad Cities	2023 (January – part of August)	• Housing situation Gender identity • Sexual orientation • Race • Ethnicity	• 361 opioid overdose reversals reported (January – part of August 2023) • 3,252 naloxone kits dispensed • 21% receiving naloxone kit were unhoused • 67% identified as male; 28% as female; 2% as transgender • 78% identified as heterosexual • 54% identified as white; 23% as black • 8% identified as Hispanic/multiracial and Hispanic

Facilitator's Guide for Focus Groups

2023 Opioid Use Assessment

September 2023

Script/Guidelines for Focus Group

Welcome and Introductions (record attendance)

Review Purpose and Ground Rules

Purpose

The focus groups are conducted on behalf of the Opioid Settlement Steering Committee, which is a local team that is working on completing a local needs assessment on opioid use in Scott County. The purpose of the focus group is to gain feedback from community members on the impact of opioid use in Scott County and how it can be addressed. We need your input and want you to share your honest and open thoughts with us.

Ground Rules

1. WE WANT YOU TO DO THE TALKING.
    a. We would like everyone to participate.
    b. We may call on you if we have not heard from you in a while.
2. THERE ARE NO RIGHT OR WRONG ANSWERS.
    a. Every person's experiences and opinions are important.
    b. Speak up whether you agree or disagree.
    c. We want to hear a wide range of opinions.
3. BE RESPECTFUL.
    a. We would like everyone to feel comfortable sharing when sensitive issues come up.
4. WE WILL BE TAKING NOTES DURING THE FOCUS GROUP SESSION.
    a. We would like to capture everything you have to say.
    b. We will not identify anyone by name in our report. You will remain anonymous.

We have a verbal consent to go over before we begin and an optional, anonymous demographics survey for you to complete at the end of the focus group.

Thank you for participating!

Review Verbal Consent

You have been asked to participate in a focus group sponsored by the Opioid Settlement Steering Committee. The purpose of the focus group is to try and understand the impact of opioid use in Scott County and how it can be addressed. The information learned in the focus groups will be used to inform the use of opioid settlement funds in Scott County.

You can choose whether or not to participate in the focus group and can stop at any time. Although notes will be taken during the focus group, your responses will remain anonymous, and no names will be mentioned in the report.

There are no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from everyone. We hope you can be honest even when your responses may not be in agreement with the rest of the group. With respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

If you understand this information and agree to participate fully under the conditions described, please stay for the focus group. If you do not wish to participate, you may leave at this time.

Definitions

- Prescription opioid use: medication prescribed by a healthcare provider
- Opioid misuse: taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high)
- Illicit opioid use: heroin, fentanyl

Warm-up Question

1. What is your favorite part about fall?

Exploration Questions

1. How does opioid use impact our community?
2. What are the challenges we should consider as we think about opioid use in our community?
3. What are the resources we should consider as we think about opioid use in our community?
4. What is the one thing you would most like to see happen to address opioid use in our community?

Other Question Ideas – these can be tailored based on the audience.

What helped you in treatment/recovery? (Consider the following: you – your personal qualities, training, education, etc.; people to whom you're close – family, church, or others in the community; local policies, programs, or services; other?)

What were the barriers if/when you sought treatment services?

What's working well in our community?

What's not working well?

If you are now in treatment or have been in treatment, where have you received services? How did you find out about those services?

If you have been in and out of treatment several times – or know other people who have had that experience; why does this happen? What is the single most important reason you personally delayed entering treatment or dropped out of treatment?

What leads people to come back into care?

How useful would it be to have a peer who could help you stay in treatment or get back into treatment?

If you could make one change to make it easier for people to get into substance use treatment, what would you do?

Some people have said that one way to address opioid use is to do X. Do you agree with this? How do you feel about that?

Are there other recommendations that you have, or suggestions you would like to make?

What trends are you seeing with prescription opioid and heroin use in this community?

What role does [sector] play in supporting individuals in treatment/recovery for opioid use disorder? What should [sector's] role be?

Exit Question

Is there anything else you would like to say about opioid use and how to address it in our community?

Probing Questions

With each inquiry, **using your judgment**, applying probing questions can help to gather information that is more detailed.

Probing is asking follow-up questions when we do not fully understand a response, when answers are unclear, or *when we want to obtain more specific or in-depth information.*

Examples of Probing Questions:

1. Could you please tell me more about…?
2. I am not quite sure I understood …Could you tell me more about that?
3. Could you give me some examples?
4. Could you tell me more about your thinking on that?
5. You mentioned….Could you tell me more about that. What stands out in your mind about that?
6. Can you give me an example of…?
7. What makes you feel that way?
8. What are some of your reasons for …?
9. You just told me about…. I would also like to know about….

Demographics Survey

Distribute paper copies and collect at the end of the focus group. The results will be anonymous; no one will be identified in the report.

Next Steps

Email notes from focus group to Opioid Core Team and copies of the demographics surveys to ellen.gackle@scottcountyiowa.gov.

Sources/Adapted from:

- Linn County Public Health
- 2021 Quad Cities Community Health Assessment
- University of Kansas, Community Tool Box: https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-focus-groups/main
- Maryland Department of Health: Behavioral Health Administration: https://health.maryland.gov/bha/ompp/documents/samplefgandkii_questions.pdf
- Target HIV, Sample Focus Group "Script" or Discussion Guide: https://targethiv.org/sites/default/files/media/documents/2021-10/CHATT-FocusGroupMaterials_attachment4_508.pdf

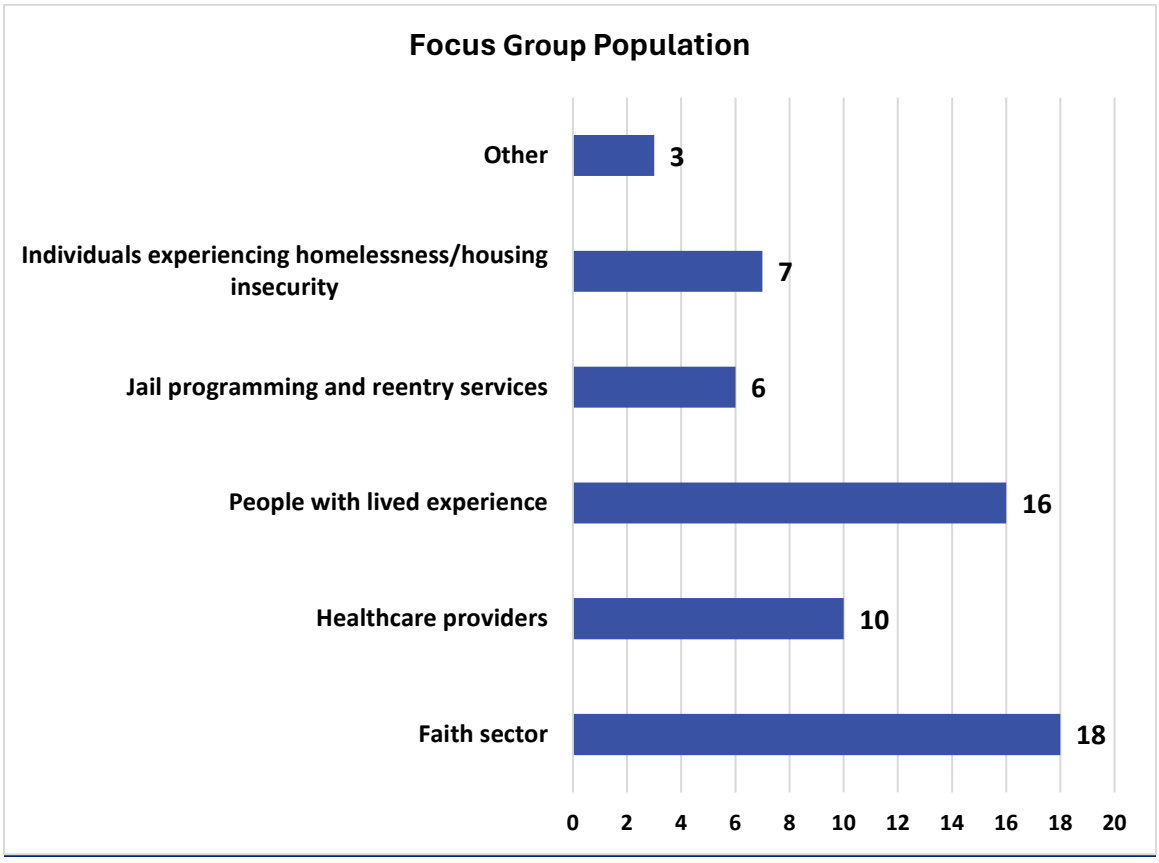
Demographic Profile of Focus Group Participants

BACKGROUND

Focus groups for the opioid settlement funds needs assessment took place between October 2, 2023, and November 2, 2023. Following the end of each focus group, participants were asked to fill out a voluntary demographic survey. Participants could choose to skip any questions they did not feel comfortable answering. There were 53 participants who completed the demographic survey. Focus groups were held with the following subpopulations: 1) faith sector; 2) healthcare providers; 3) people with lived experience; 4) jail programming and reentry services; 5) youth; and 6) individuals experiencing homelessness/housing insecurity. The following sections describe various characteristics of the participants for these focus groups.

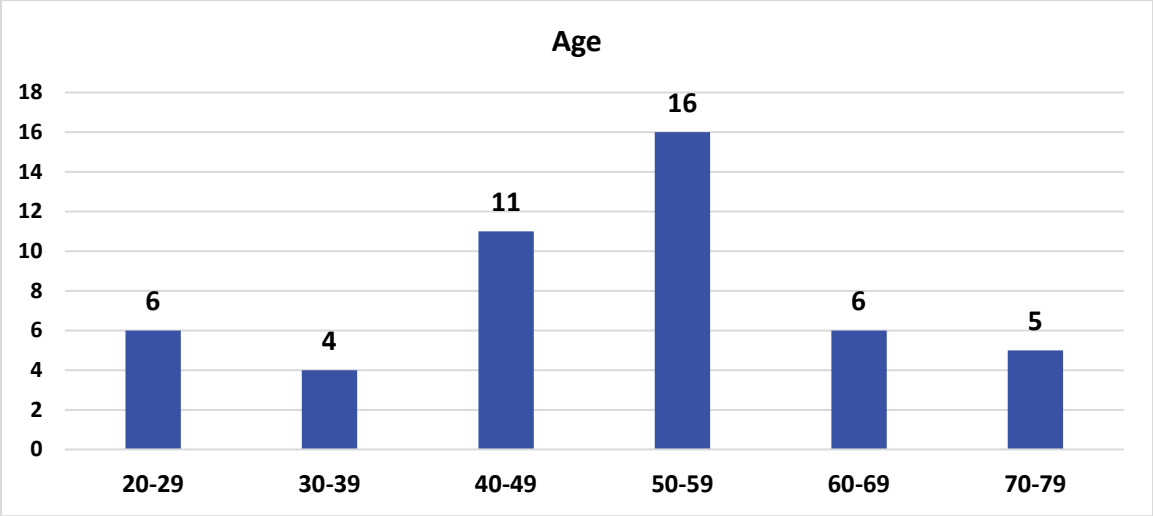
FOCUS GROUP POPULATION

Participants were asked which focus group population they represented. Some participants selected one or more groups they identified with, so numbers below are duplicated in some areas. Forty-nine participants completed the question and four did not respond. The percentages are based on who responded. Eighteen respondents (37%) were part of the faith sector, sixteen (33%) were individuals with lived experience, ten (20%) were healthcare providers, seven (14%) were individuals experiencing homeless/housing insecurity, six (12%) had experience with jail programming and reentry services, and three (6%) identified as other.



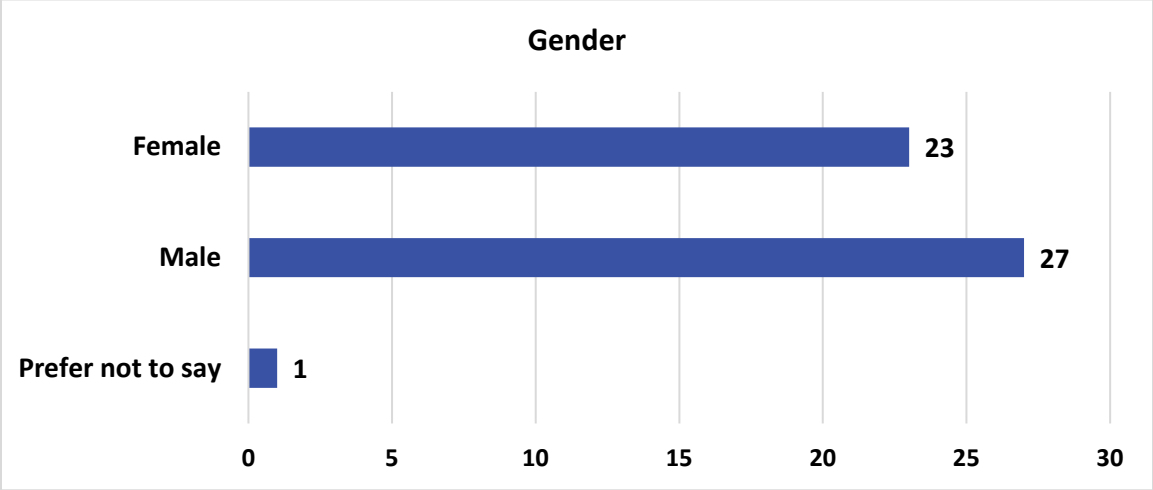
AGE IN YEARS OF PARTICIPANTS

Forty-eight participants completed the question and five did not respond. The percentages are based on who responded. Six (13%) were between the ages of 20-29 years old, four (8%) were 30-39 years old, eleven (23%) were 40-49 years old, sixteen (33%) were 50-59 years old, six (13%) were 60-69 years old, and five (10%) were 70-79 years old.



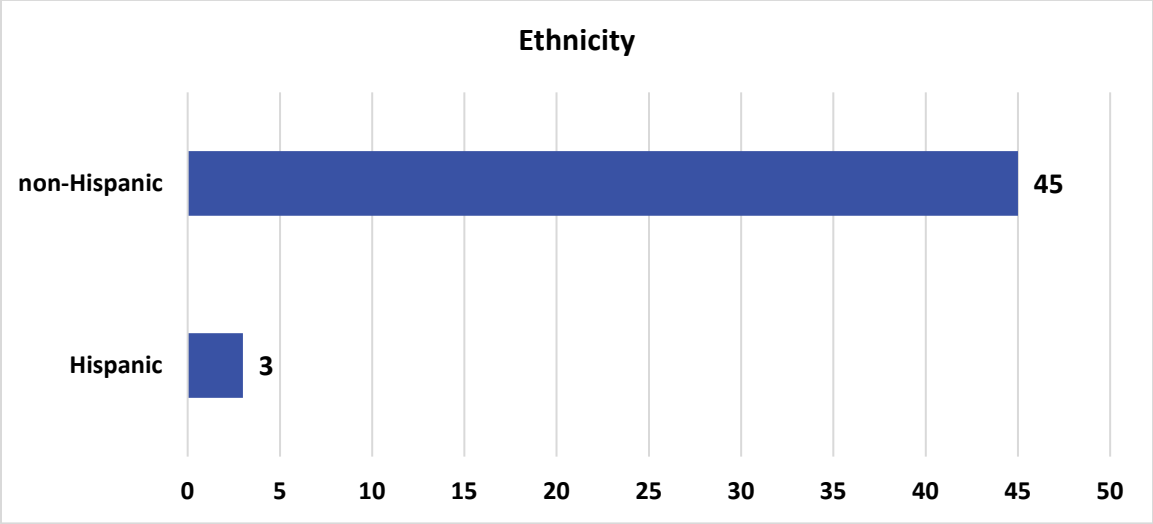
GENDER OF PARTICIPANTS

Fifty-one participants completed the question and two did not respond. The percentages are based on who responded. Twenty-seven (53%) identified as male, twenty-three (45%) identified as female, and one (2%) preferred not to say.



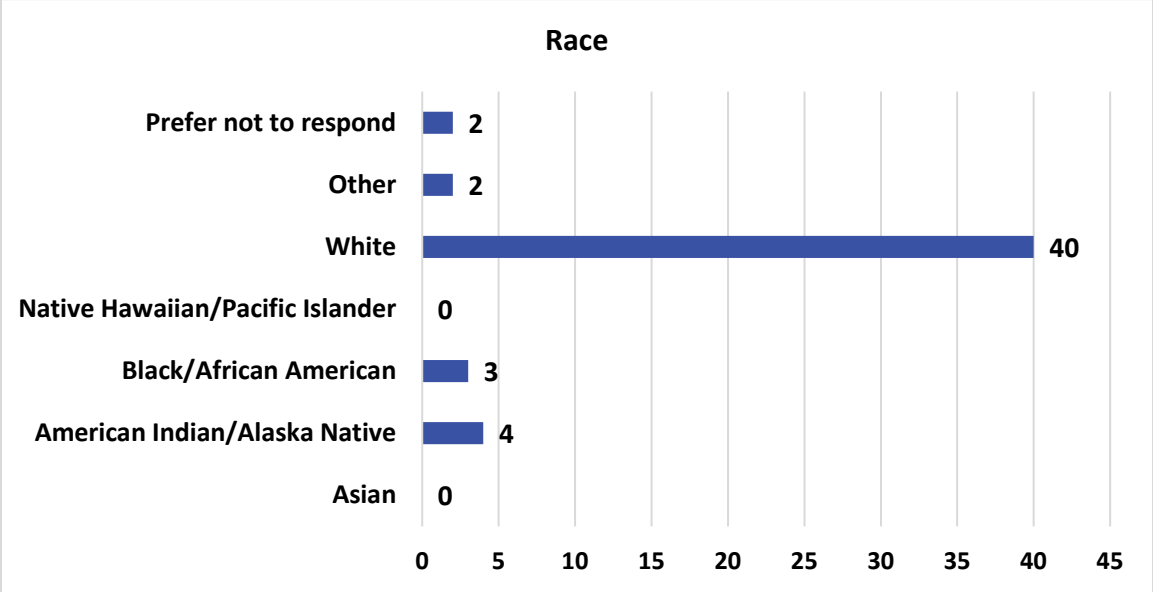
ETHNIC GROUPS PARTICIPANTS IDENTIFY WITH

Forty-eight participants completed the question and five did not respond. The percentages are based on who responded. The majority of respondents (45 or 94%) identified as non-Hispanic. Three (6%) identified as Hispanic.



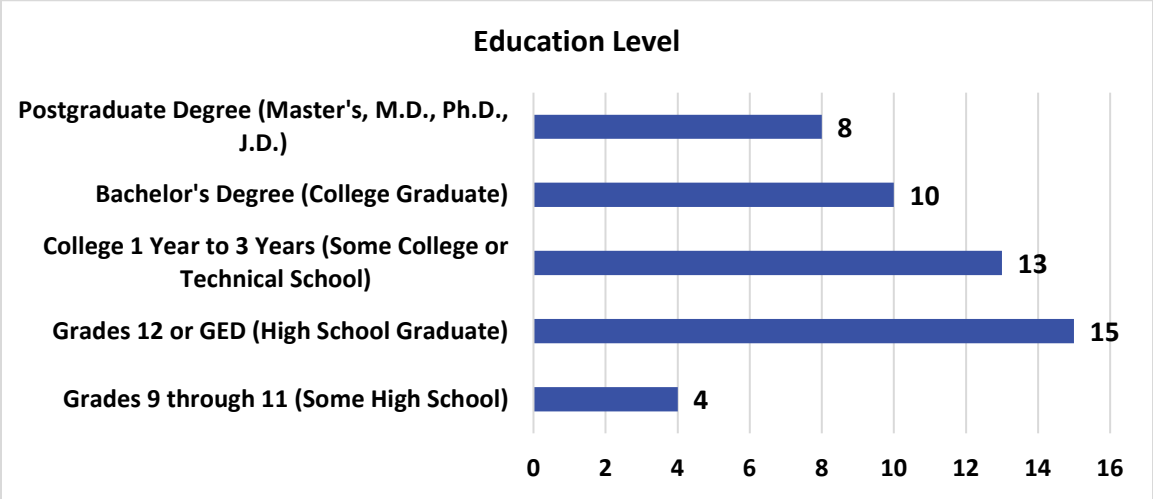
RACIAL GROUP PARTICIPANTS AFFILIATE WITH MOST

Fifty participants completed the question and three did not respond. The percentages are based on who responded. The majority of participants (40 or 80%) identified as White.



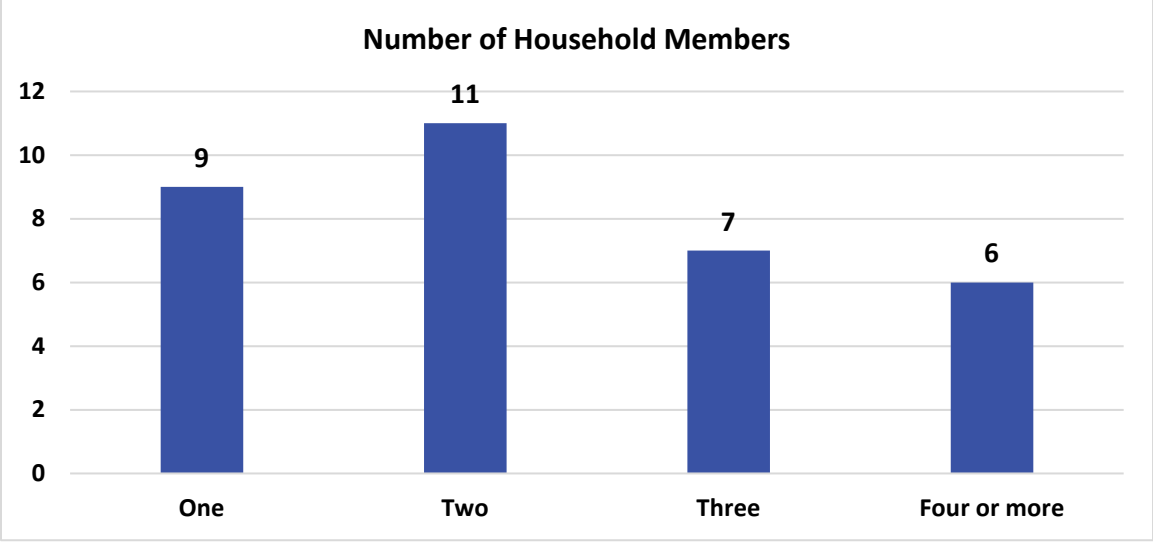
HIGHEST GRADE OR YEAR OF SCHOOL COMPLETED

Fifty participants completed the question and three did not respond. The percentages are based on who responded. Fifteen (30%) of participants graduate high school (Grade 12 or GED); thirteen (26%) of participants completed 1-3 years of college or technical school; ten (20%) completed a Bachelor's degree; eight (16%) completed a postgraduate degree, and four (8%) completed some high school (grades 9 through 11).



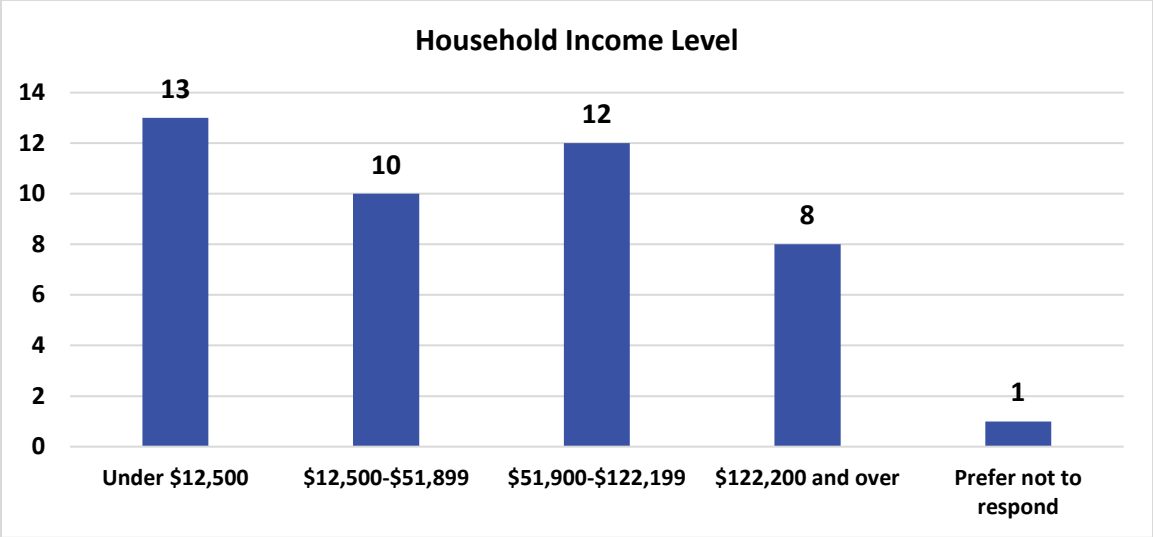
TOTAL NUMBER OF HOUSEHOLD MEMBERS

Thirty-five participants completed the question and eighteen did not respond. The percentages are based on who responded. Eleven (31%) reported two household members followed by nine (26%) who reported one household member, seven (20%) reported three household members, and six (17%) who reported four or more household members.



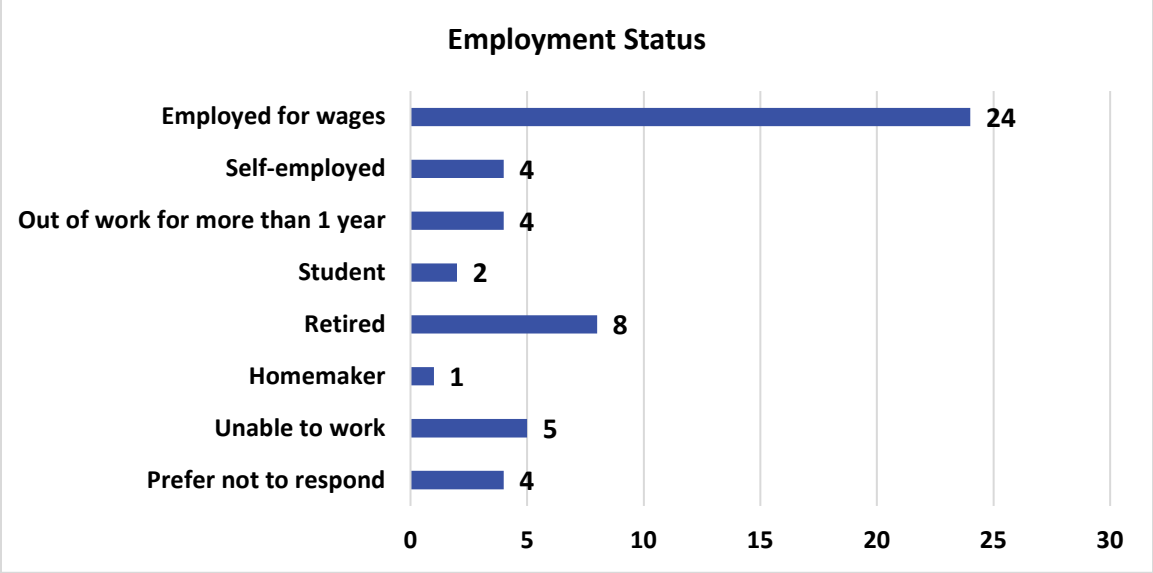
TOTAL ESTIMATED HOUSEHOLD INCOME

Forty-six participants completed the question and seven did not respond. The percentages are based on who responded. Thirteen (28%) indicated a household income of under $12,500, followed by eight (17%) who reported a household income of $122,200 and over.



EMPLOYMENT STATUS

Forty-eight participants completed the question and five did not respond. The percentages are based on who responded. The majority of participants (24 or 50%) were employed for wages. Eight (17%) were retired, five (10%) responded they were unable to work, four (8%) were self-employed, four (8%) have been out of work for more than 1 year, four (8%) preferred not to respond, two (4%) were students, and one (2%) was a homemaker.

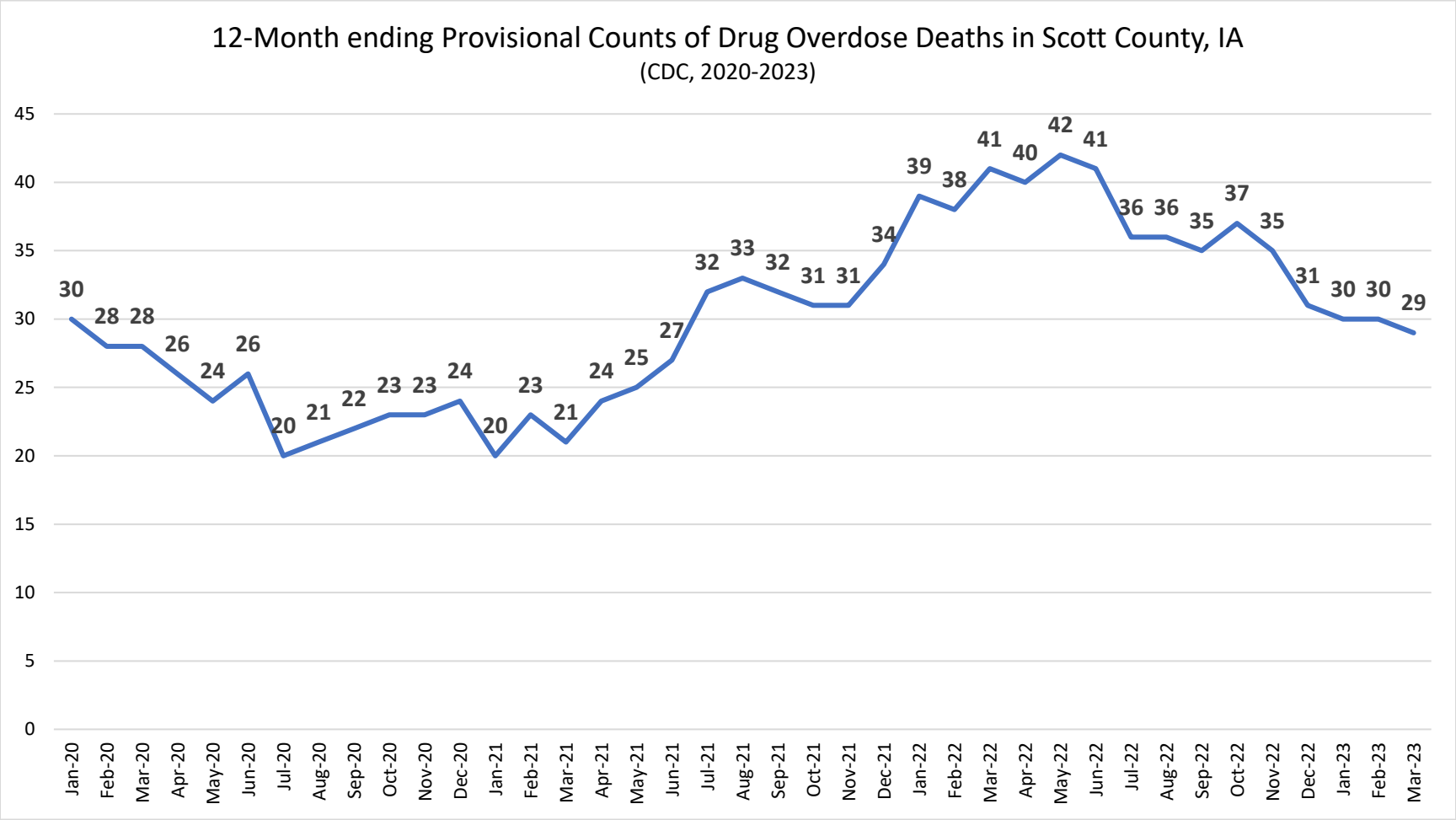


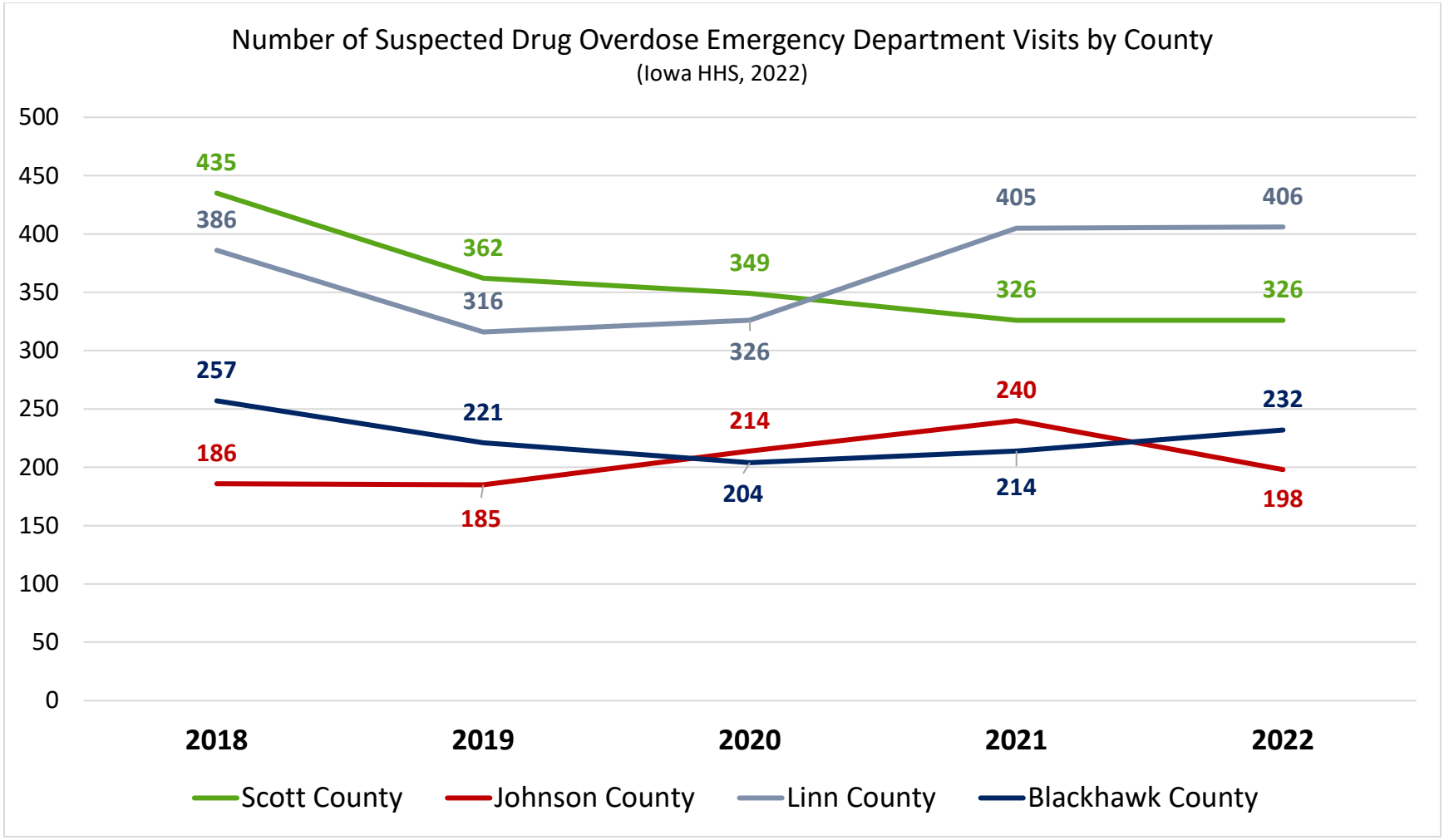
Opioid Use Needs Assessment

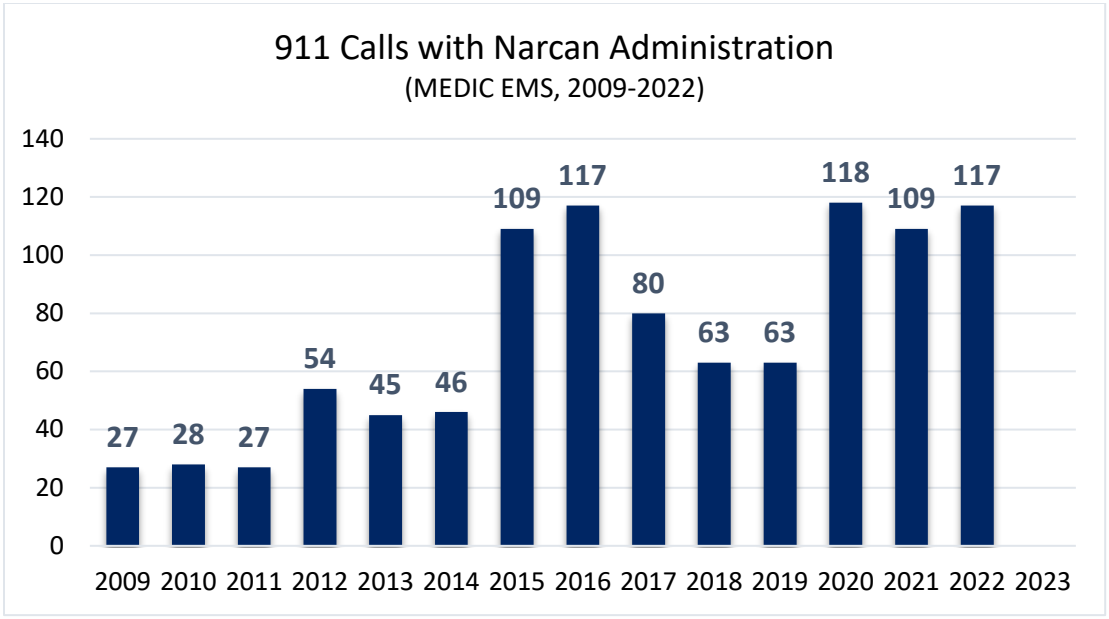
Scott County, IA

October 2023

Opioid Use / Overdoses




Number of Suspected Drug Overdose Emergency Department Visits by County
(Iowa HHS, 2022)
500
450
400
350
300
250
200
150
100
50
0
435
362
349
326
326
386
316
326
405
406
257
221
204
214
232
186
185
214
240
198
2018
2019
2020
2021
2022
Scott County
Johnson County
Linn County
Blackhawk County

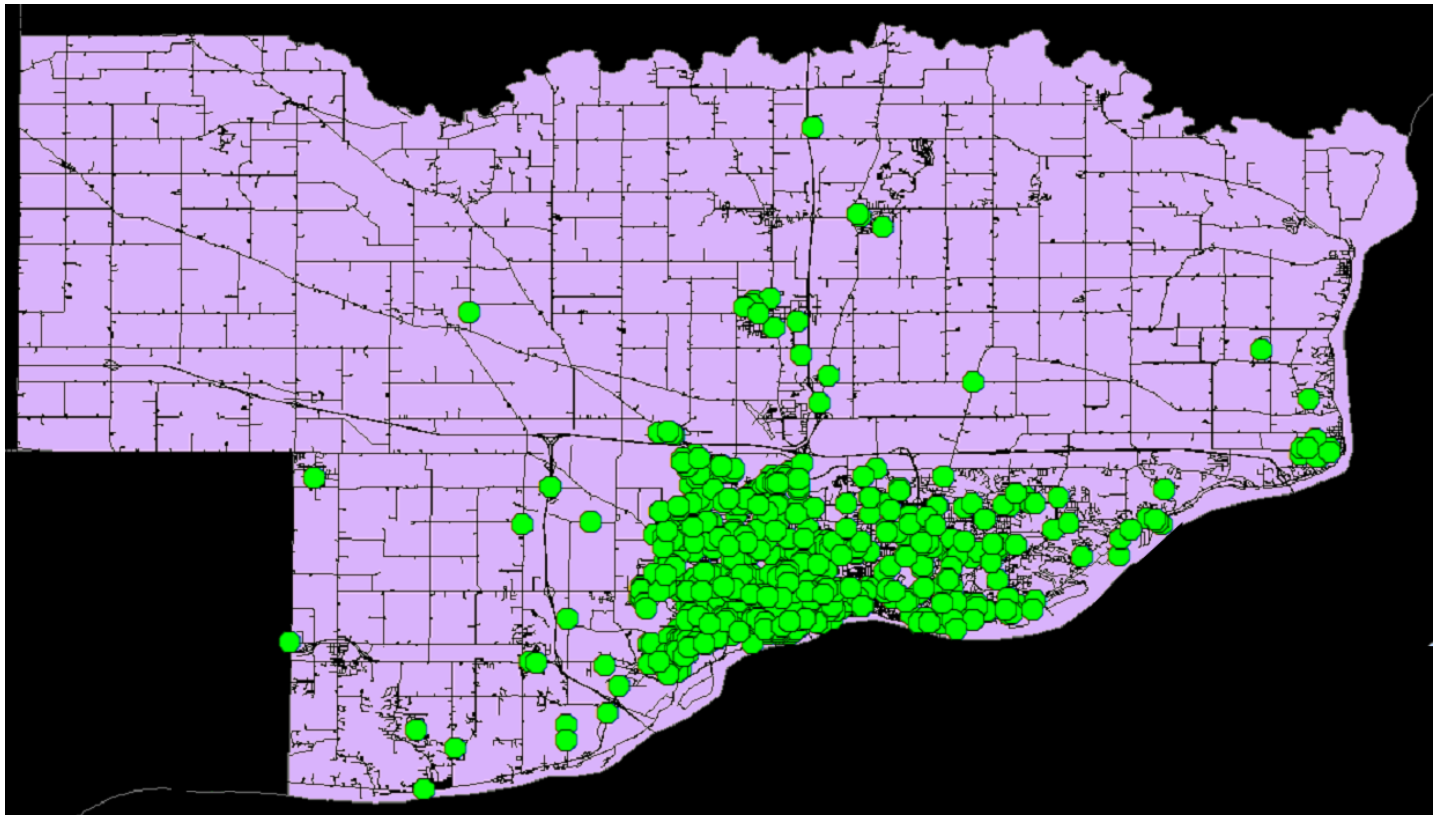


Age Distribution

	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
<18	2	6	3	6	7	7	6	11	6	48
18-30	28	45	45	51	36	38	48	63	45	354
31-40	24	29	37	43	54	53	67	65	49	372
41-50	27	33	40	52	41	42	52	55	54	342
51-60	21	27	25	46	70	51	67	71	60	378
61-70	10	10	22	48	50	49	62	62	58	313
>70	22	15	28	40	65	65	90	89	76	414
Total	**134**	**165**	**200**	**286**	**323**	**305**	**392**	**416**	**348**	

Gender Distribution

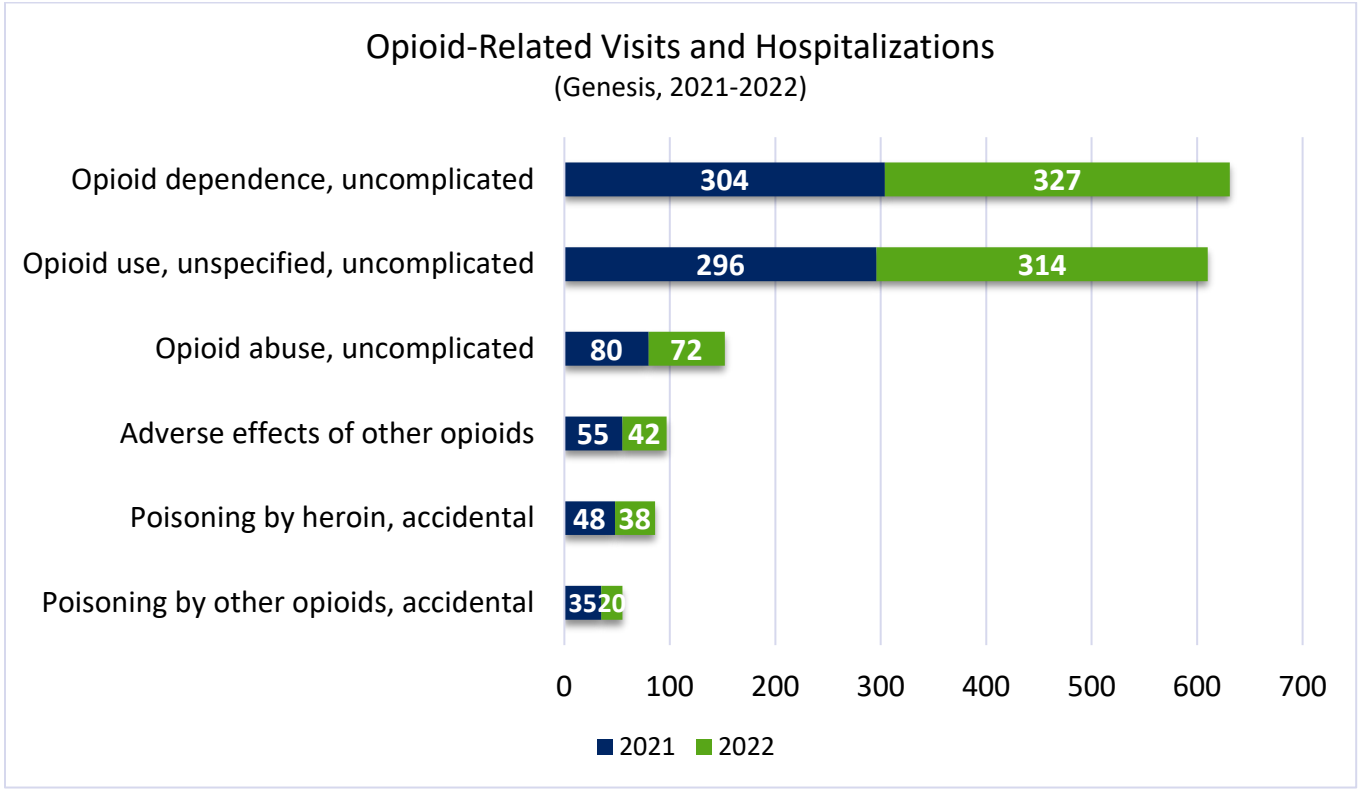
	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
Female	70	77	90	114	138	122	163	164	125	938
Male	62	88	110	171	185	183	229	252	223	1280
Unknown	2	0	0	1	0	0	0	0	0	3
Total	134	165	200	286	323	305	392	416	348	



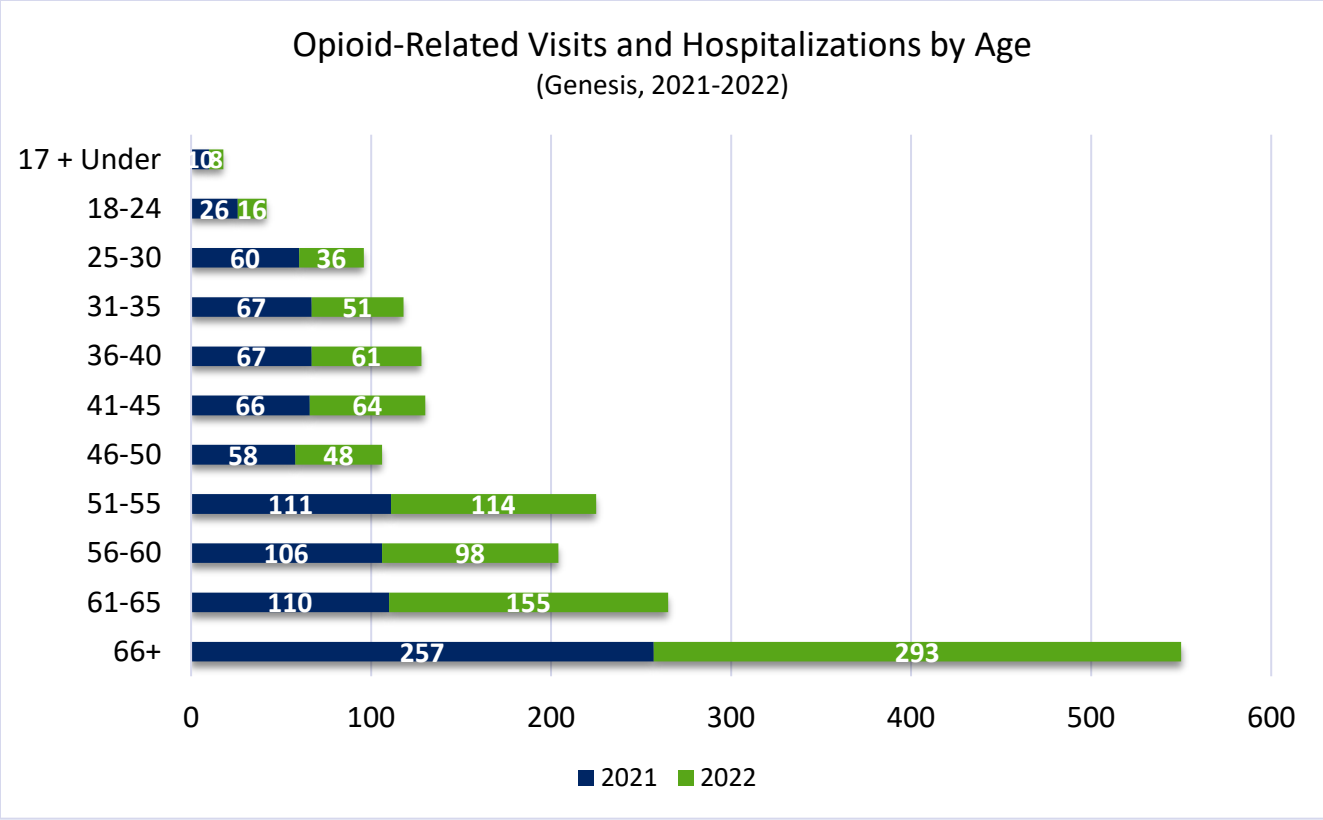
911 Calls with Narcan Administration (MEDIC EMS)

2009-2022 = 1004 Calls

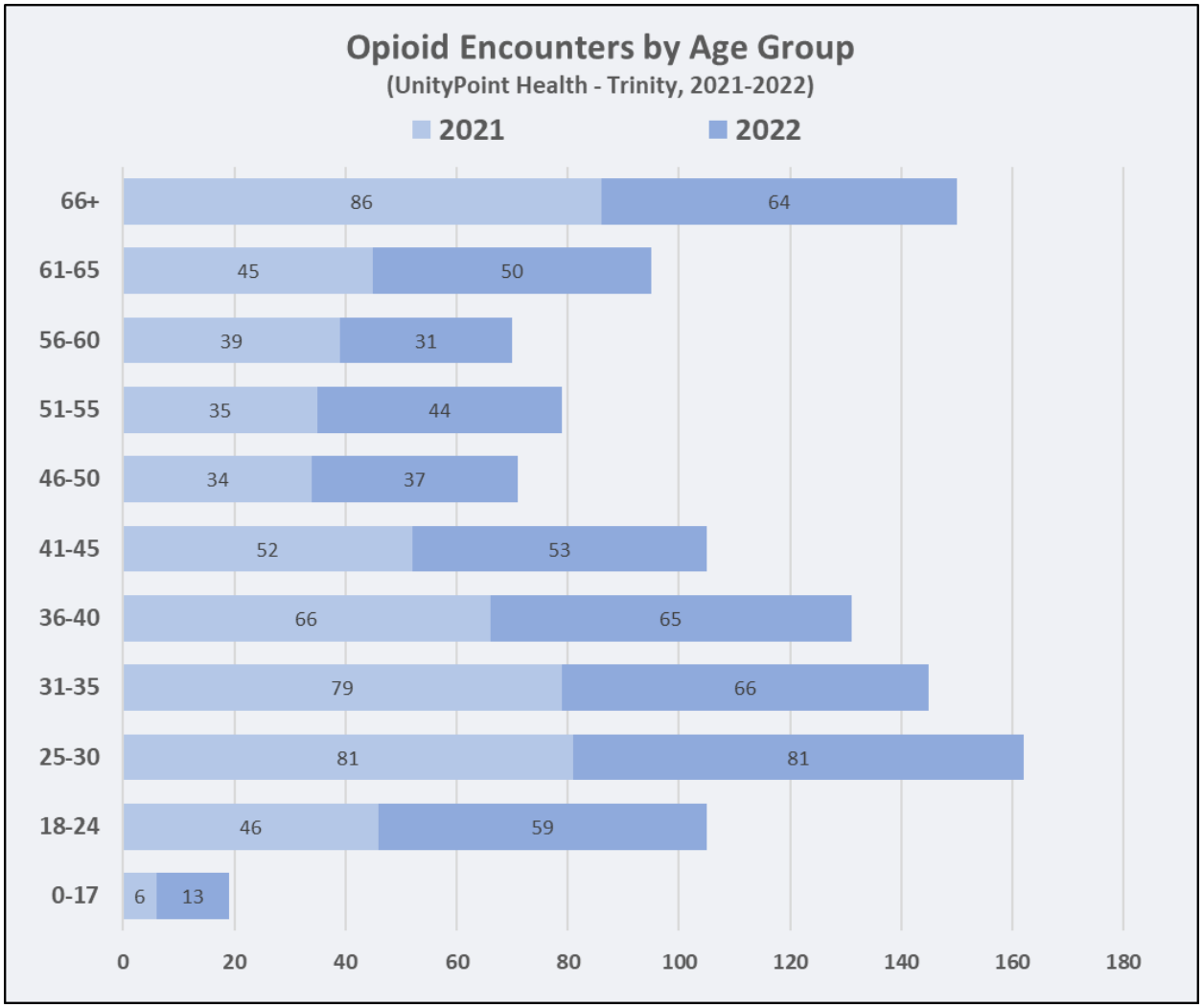
All fire departments and ambulance services in Scott County carry Narcan.
Police departments in Scott County who carry Narcan: • Davenport • Bettendorf • Buffalo • Scott County Conservation • Scott County Sheriff



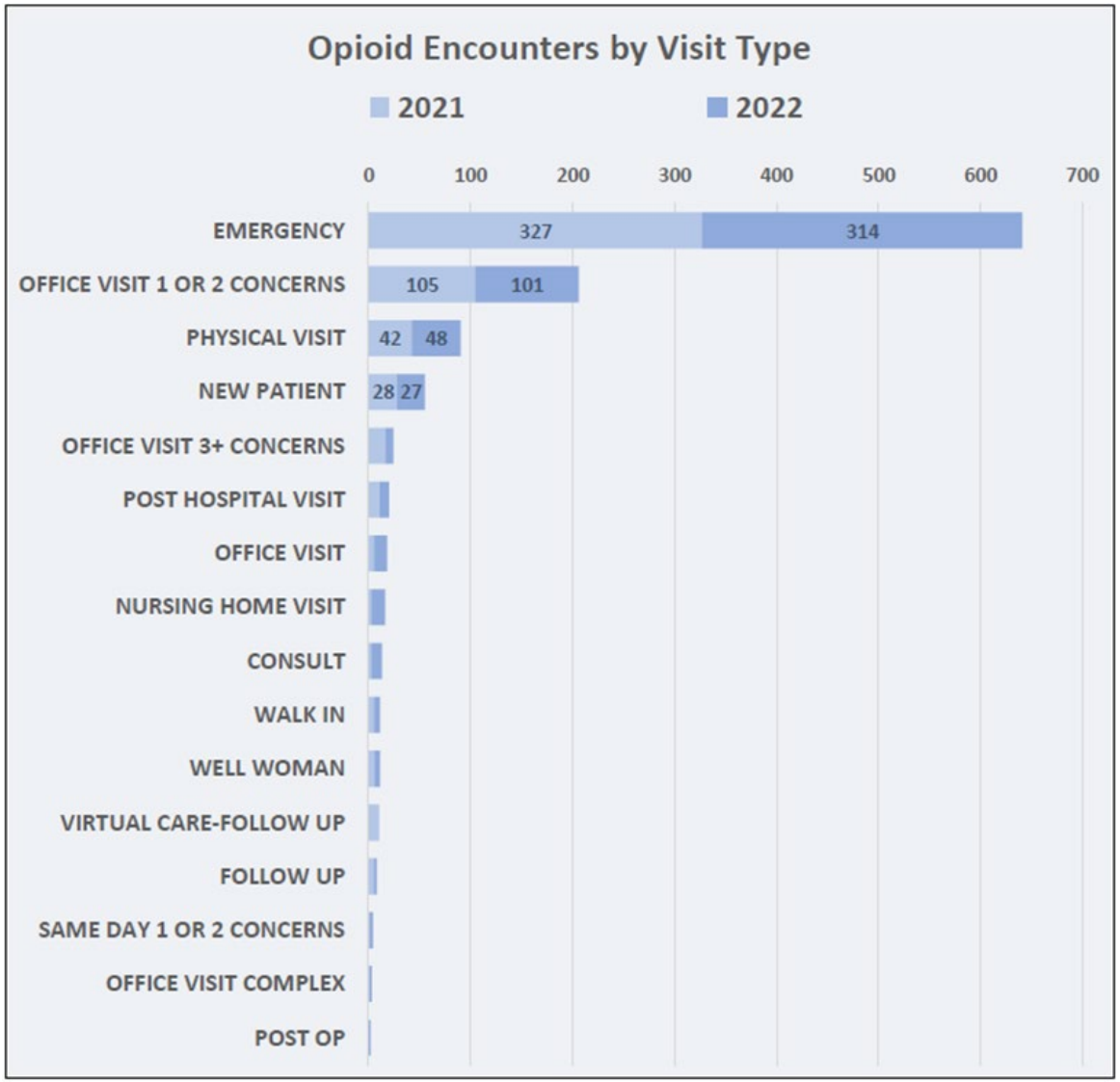
Opioid dependence, uncomplicated accounted for 32% of visits. Opioid use, unspecified, uncomplicated accounted for 31%.



Between these two years, the 66+ population accounts for 29.2% of encounters. Those aged 51+ accounted for 66.2% of encounters.



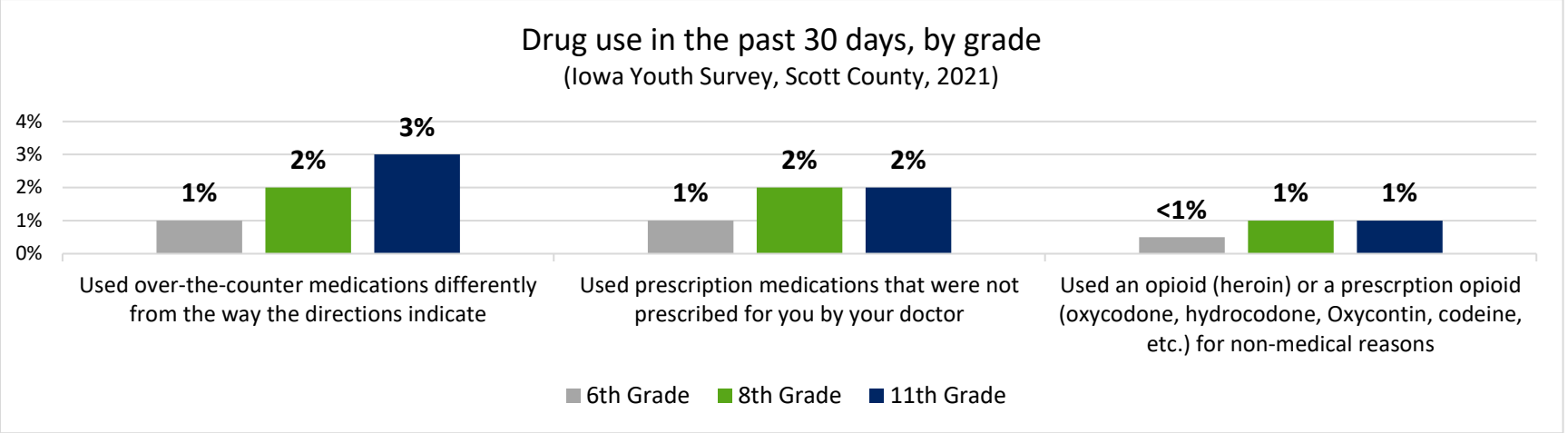
Between these two years, 14.3% of encounters were among 25-30 year olds. 13.3% were among those 66+.



Between these two years, most encounters (56.6%) were in an emergency setting.

Prevention

Quantitative



Qualitative

Focus Group Themes
<u>Education</u> • Youth • Prescribers • Community members • Stigma
<u>Training</u> • To providers on opioids and alternatives to pain management • To community members on opioid use, Narcan administration, resources, etc.
<u>Policy</u> • Ease of getting prescription opioids

Systems • Establish preventative measures to address issues before they become a problem
Environments • Education to family members and friends on opioids, Narcan administration, resources, etc. • Building support systems for individuals to reduce risk of using or overdosing

Known Resources/Services

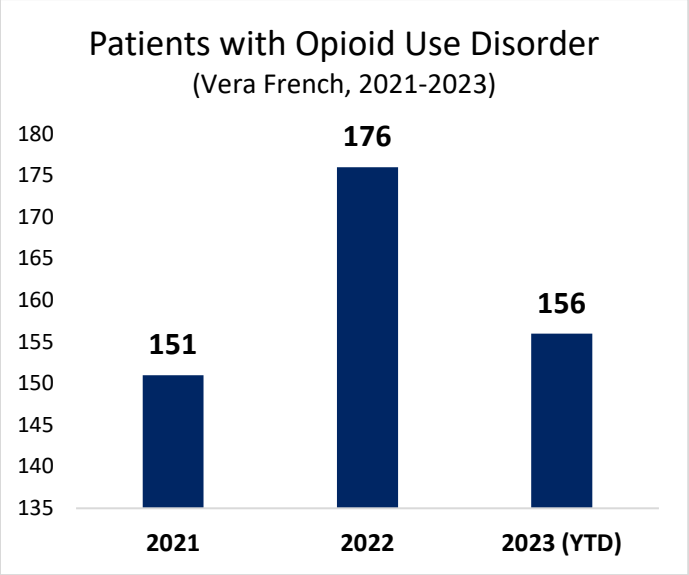
Center for Alcohol and Drug Services (CADS): providing some prevention education in the schools (Prime 4 Life & Project Towards No Drugs)
One Eighty: prevention initiatives at The Hope Center
Medication disposal bins at pharmacies
Medication disposal packets at pharmacies

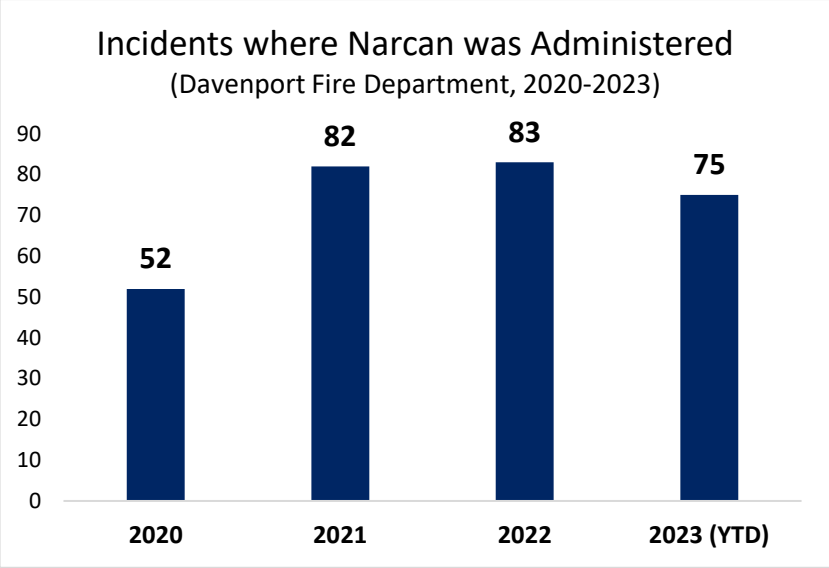
Core Strategies – Schedule A

Enrich prevention strategies
1. Funding for media campaigns to prevent opioid use. 2. Funding for evidence-based prevention programs in schools. 3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing). 4. Funding for community drug disposal programs. 5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and programs.

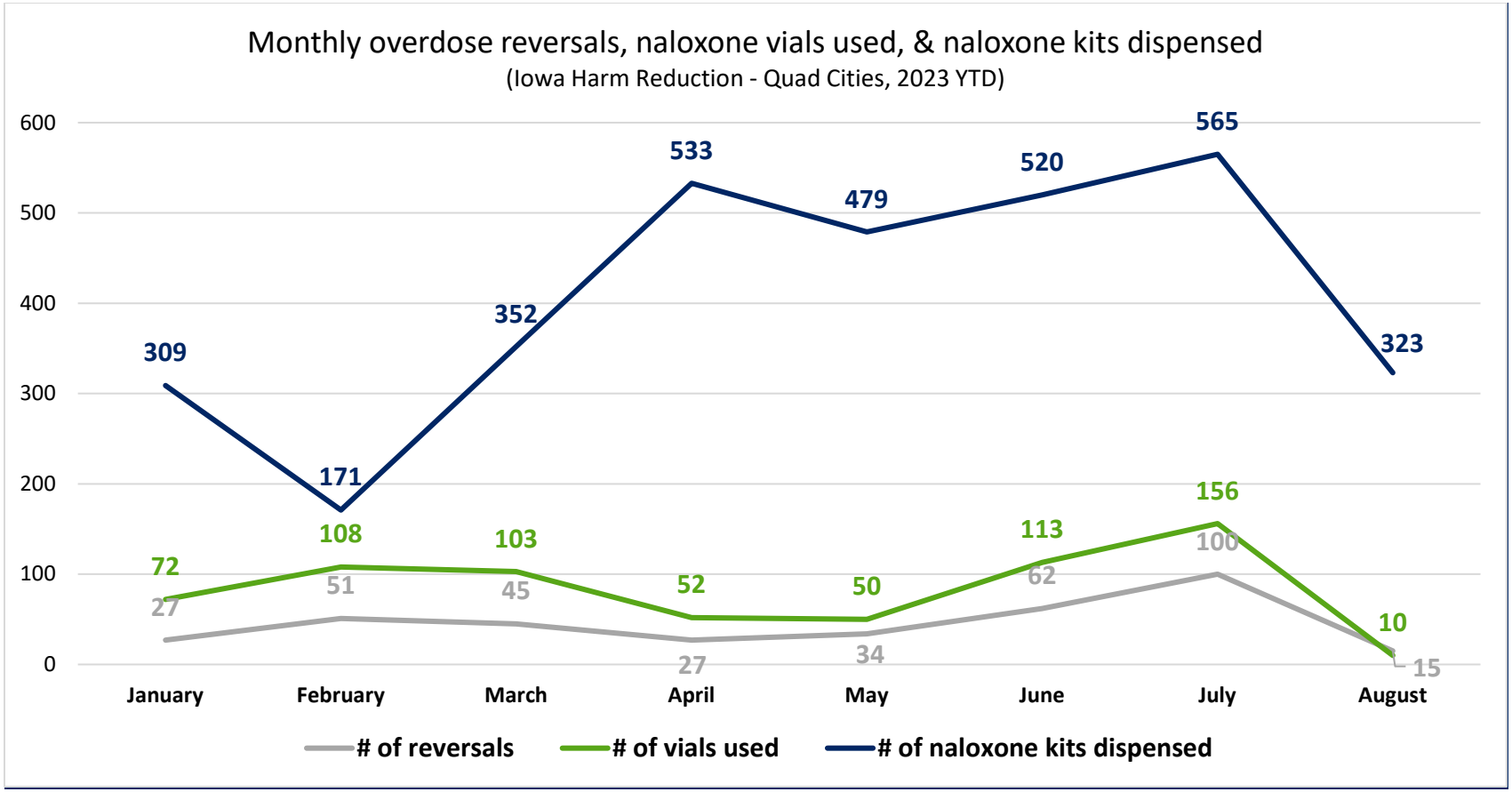
Treatment / Harm Reduction

Quantitative





2023 (YTD) data as of August 31, 2023.


Monthly overdose reversals, naloxone vials used, & naloxone kits dispensed
(Iowa Harm Reduction - Quad Cities, 2023 YTD)
600
500
400
300
200
100
0
309
171
352
533
479
520
565
323
72
108
103
52
50
113
156
10
27
51
45
27
34
62
100
15
January
February
March
April
May
June
July
August
# of reversals
# of vials used
# of naloxone kits dispensed

Qualitative

Focus Group Themes
Education • Lack of awareness of treatment resources • Stigma
Training • How to recognize and respond to overdose
Policy • Naloxone should be more available: upon release from jail/hospital, sent home with opioid prescriptions, by law enforcement, etc. • Follow up to overdose: case navigation/coordination would be helpful • Medication Assisted Treatment (MAT): access to MAT is limited (low # of providers who practice MAT)
Systems • Limited treatment options, especially without insurance • Financial barriers to accessing treatment services (private insurance v. Medicaid) • Lack of detox options • Unable to enter treatment facilities if not actively using (no substances in system)
Environments • Lack of housing • Transportation barriers

Known Resources/Services

Rosecrance: outpatient treatment for both adults and youth
CADS: evaluations and outpatient treatment
Center for Behavioral Health: methadone clinic
Iowa Harm Reduction Coalition – Quad Cities: distribute naloxone, safer injection kits, and risk reduction supplies
One Eighty: 14-month residential program for men and women
The Abbey: outpatient and residential treatment programs

Core Strategies – Schedule A

Broaden access to naloxone
1. Expand training for first responders, schools, community support groups and families. 2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.
Increase use of medications to treat opioid use disorder
1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service. 2. Provide education to school-based and youth-focused programs that discourage or prevent misuse. 3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders. 4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.
Provide treatment and supports during pregnancy and the postpartum period.
1. Expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to non-Medicaid eligible or uninsured pregnant women. 2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (OUD) and other Substance Use Disorder (SUD)/Mental Health disorders for uninsured individuals for up to 12 months postpartum. 3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.
Expand services for neonatal withdrawal syndrome
1. Expand comprehensive evidence-based and recovery support for NAS babies. 2. Expand services for better continuum of care within infant-need dyad. 3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.
Improve treatment in jails and prisons
1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system. 2. Increase funding for jails to provide treatment to inmates with OUD.
Expand harm reduction programs
1. Provide comprehensive syringe service programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

Recovery

Quantitative

Recovery Ecosystem Index developed by the National Opinion Research Center (NORC) at University of Chicago and East Tennessee State University.

Scott County, IA

Recovery Ecosystem Index Score

3.0 1=strongest; 5=weakest

172,938 Population (Urban)

Hover over a variable in the data table, and its definition will appear below

Component	Score	Sub-Component	Scott County, IA	Iowa	United States
SUD Treatment	3	Substance Use Treatment Facilities per 100k	**3.5**	5.7	4.3
		Buprenorphine Providers per 100k	**2.9**	6.1	15.2
		Average Distance to Nearest MAT Provider (miles)	**8.0**	N/A	N/A
		Mental Health Providers per 100k	**146.3**	176.3	284.4
Continuum of SUD Support	2	Recovery Residences per 100k	**1.2**	1.0	1.0
		Average Distance to Nearest SSP (miles)	**46.5**	N/A	N/A
		NA or SMART Meetings per 100k	**6.4**	9.5	8.1
		Is there a Drug-Free Communities Coalition?	**No**	6.1%	15.6%
		Is there a Drug Court?	**Yes**	13.1%	48.2%
		State SUD Policy Environment Score (10=highest; 0=lowest)	**4.0**	4.0	N/A
Infrastructure and Social	3	One or More Vehicles	**94.2%**	94.3%	91.5%
		Broadband Access	**83.6%**	83.1%	85.2%
		Social Associations per 10k	**9.7**	12.8	8.7
		Severe Housing Cost Burden	**11.3%**	9.9%	13.0%

Qualitative

Focus Group Themes
Education • Lack of awareness of recovery resources (e.g., sober living) • Recovery is a long-term process
Training • Transition from treatment to recovery: treatment facilities don't set up long-term follow up care
Policy • Admission policies (relapse is common)
Systems • Financial barriers to recovery resources (e.g., sober living)
Environments • Transition from treatment to recovery: people end up back in the same situations/environments

Known Resources/Services

One Eighty: stability housing option upon completion of residential program
Destination Recovery Homes: sober living residences for men (3) and women (2)
Narcotics Anonymous
Rosecrance: recovery support groups for both adults and youth
Public Science Collaborative: recovery resources map and community profiles

Core Strategies – Schedule A

Fund warm hand-off programs and recovery services
1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments. 2. Expand warm hand-off services to transition to recovery services. 3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions. 4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare. 5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

Prioritization Criteria Evaluation

Criteria	Core Strategy #1: Broaden Access to Naloxone AND Core Strategy #8: Expand Harm Reduction Programs		Core Strategy #2: Increase Use of Medications to Treat Opioid Use Disorder		Core Strategy #3: Provide Treatment and Supports During Pregnancy and the Postpartum Period		Core Strategy #4: Expand Services for Neonatal Opioid Withdrawal Syndrome	
Cost	High	1	High	1	High	1	High	1
Ease of Implementation	Easy	5	Hard	1	Hard	1	Hard	1
Impact (Type)	System	5	System	5	Program	1	Program	1
Expand/enhance	Yes	5	Yes	5	Yes	5	No	1
Community Impact (Number)	High	5	High	5	Low	1	Low	1
Total		21		17		9		5

Score:

Cost	Ease of Implementation	Impact (Type)	Expand/Enhance	Community Impact (Number)
High = 1 Low = 5	Hard = 1 Easy = 5	Program = 1 System = 5	No = 1 Yes = 5	Low = 1 High = 5

Criteria	Core Strategy #5: Fund Warm Handoff Programs and Recovery Services		Core Strategy #6: Improve Treatment in Jails and Prisons		Core Strategy #7: Enrich Evidence-Based Prevention Strategies		Core Strategy #9: Support Data Collection and Research	
Cost	High	1	Low	5	Low	5	Low	5
Ease of Implementation	Hard	1	Easy	5	Easy	5	Easy	5
Impact (Type)	System	5	Program	1	System	5	System	5
Expand/enhance	Yes	5	Yes	5	Yes	5	Yes	5
Community Impact (Number)	High	5	High	5	High	5	High	5
Total		17		21		25		25

Score:

Cost	Ease of Implementation	Impact (Type)	Expand/Enhance	Community Impact (Number)
High = 1 Low = 5	Hard = 1 Easy = 5	Program = 1 System = 5	No = 1 Yes = 5	Low = 1 High = 5

	#1 & #8	#2	#3	#4	#5	#6	#7	#9
Cost	1	1	1	1	1	5	5	5
Ease of Implementation	5	1	1	1	1	5	5	5
Impact (Type)	5	5	1	1	5	1	5	5
Expand/enhance	5	5	5	1	5	5	5	5
Community Impact (Number)	5	5	1	1	5	5	5	5
Total	**21**	**17**	**9**	**5**	**17**	**21**	**25**	**25**

Score:

Cost	Ease of Implementation	Impact (Type)	Expand/Enhance	Community Impact (Number)
High = 1 **Low = 5**	**Hard = 1** **Easy = 5**	**Program = 1** **System = 5**	**No = 1** **Yes = 5**	**Low = 1** **High = 5**

Opioid Settlement Funds Strategic Planning
January 8, 2024, 8:00-10:00 am
Scott County Administration Center, First Floor Boardroom

Eisenhower Matrix