NCIOM

North Carolina Institute of Medicine

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PRACTICAL CONSIDERATIONS FOR NORTH CAROLINA'S COMMUNITY LEADERS:

THE CHALLENGES, OPPORTUNITIES, AND TRANSFORMATIVE POTENTIAL OF OPIOID SETTLEMENT FUNDS

> *We identified a shared vision among our participants: saving lives, centering people with lived experience, and improving the quality of life for those with opioid use disorder*

The opioid crisis and its consequences have affected so many of us in North Carolina. Nearly all the people we interviewed for this report have a personal relationship to the opioid crisis. Some people were in recovery, and many others discussed loving someone who struggled with an opioid use disorder or who lost their life due to overdose. If you work in or close to this field, you may have witnessed people in your community experience devastating events associated with substance use disorders: illness, incarceration, unemployment, housing instability, violence, and loss of life.

You may have also experienced recovery and improved quality of life achieved through a variety of means—the use of effective medications for opioid use disorder, the social support of faith communities and other networks of shared values, access to stable housing and employment, and mental health treatment and counseling. All of these experiences, personal and professional, are with us when we convene to discuss strategic planning related to opioid settlement funds.

We can't avoid the reality of the challenges of this work. Many of our most committed leaders find themselves overwhelmed by the scope of opioid-related issues in our communities. Our interviews touched on issues that elicit strong feelings from people with differing perspectives. Depending on the community, these disparate views may result in the avoidance of contentious but necessary topics during the strategic planning process. We hope that by acknowledging these challenges in this report, we can help to spur open, honest communication, learning, and ultimately the progress necessary to effectively serve our communities.

Alongside these challenges, we identified a shared vision among our participants: saving lives, centering people with lived experience, and improving the quality of life for those with opioid use disorder. This shared vision can provide the common ground on which trust and progress are cultivated.

You have already begun the mission to improve the health of your community. We hope to equip you with information on the experiences of leaders across North Carolina that can help inform the discussions you have in your own community. We aspire to communicate a spectrum of perspectives, help you navigate these topics with respect, and encourage you in this life-changing work.

Thank you for all you have done. Thank you for what you will continue to do.

Between December 2021 and October 2022, North Carolina Institute of Medicine (NCIOM) staff spoke with 62 North Carolinians about their perspectives on the current strengths, challenges, and opportunities of substance use education, prevention, and services in communities across our state. **We wanted to understand the current challenges faced by people with substance use disorder and the organizations that serve them. We also wanted to understand how North Carolina communities were preparing for the important work of determining how to effectively use new and potentially transformative funding from the financial settlements relating to national opioid litigation.** This report represents a "snapshot in time" at a critically important moment, when the settlement funding was still very new but the contours of this opportunity were coming into focus, and important decisions and plans were starting to gel.

We chose to ask these North Carolinians some of the toughest questions related to opioid settlement decision-making, and raise important issues that challenge many communities across our state:

- the implementation of **HARM REDUCTION** strategies
- integrating **SOCIAL SUPPORTS** (such as housing assistance) into treatment programs
- achieving **RACIAL EQUITY** in process and outcomes
- the **MEANINGFUL INCLUSION OF PEOPLE WHO USE DRUGS** in the planning of programs designed for their benefit

We chose the topics listed in the box above for three reasons. First, we observed that many communities struggled to do these things well, and we believed that in order to make progress, it would be helpful to learn more about why these issues are so difficult. We also wanted to learn from North Carolinians about what was working well in these areas. Second, each of these topics has a compelling scientific evidence base. ***Communities that learn to do these things well can expect to achieve stronger outcomes.*** Third, service providers are often understandably overwhelmed with daily tasks of logistics, project management, and personnel. The topics we raise here require deeper levels of reflection and collaboration. When you're putting out fires all day long, it can feel impossible to make time to reflect on doing this work differently. It is our hope that this report will provide that opportunity for our community members who commit to this work every day. We hope you'll see yourselves in these pages, and see our respect for your contributions to our communities and state.

So, what did we hear from these 62 thinkers and doers? We sum up their observations and recommendations as follows:

STRATEGIC PLANNING, DECISION-MAKING, AND ACCOUNTABILITY

County leaders should be aware of the contributions and seasoned experience of existing service providers, and integrate them as much as possible into settlement funding plans. This includes many organizations that do not have a "seat at the table" but provide effective services or broker unique relationships and trust. Interviewees recommend that settlement fund decision-makers look with appropriate scrutiny at pet projects, at ideas that may have worked elsewhere but have not been proven in similar communities, and at organizations with little experience and knowledge of the evidence base that are tempted to expand their missions to make use of this new funding stream.

Settlement fund decision-makers should strive to establish agreed-upon goals and outcome metrics for impact evaluation. These metrics should be transparent and easily accessible to all county residents. Additionally, community partners should decide on when and how often to meet to evaluate progress and adjust strategies to meet community goals.

RECOVERY, ABSTINENCE-BASED TREATMENT, AND HARM REDUCTION

Communities should openly discuss how they measure success, and especially how they define the concept of **recovery**. Some may define recovery as complete sobriety through the treatment of underlying causes of addiction, such as mental illness, trauma, or economic deprivation. Others may encourage people who use drugs to define recovery for themselves and focus on reducing the negative consequences of substance use through strategies like HIV/HCV testing, syringe exchange, and naloxone distribution. Different definitions of recovery and preferred strategies for addressing substance use provide an opportunity for decision-makers to engage people with lived experience in strategic planning.

Settlement fund decision-makers should initiate strategic planning conversations with thoughtful discussion about the role of recovery and its potential measurement. Common ground can be leveraged to forge agreement on consensus- and values-driven goals and evaluation metrics, such as deaths due to opioid overdose, opioid overdose, contact(s) with the criminal justice system, contact(s) with social services, housing and food security, educational and vocational enrollment, and employment.

THE CONSEQUENCES OF STIGMA

Our interviews consistently identified stigma as a persistent barrier for people seeking services and treatment for substance use disorder. People turn stigma on themselves, believing their substance use justifies their experiences of mistreatment or victimization. They experience stigma in interactions with service providers, and often choose to forgo treatment—even in emergencies—because they do not want to be subject to discrimination or because they fear the consequences of mandatory reporting laws, for example.

Settlement fund decision-makers should initiate conversations about stigma during planning meetings, revisiting this issue repeatedly. The experiences and insights of people who use drugs are especially valuable here. They can teach settlement planning teams about when and how they experience stigma and identify the best practices of the organizations that have effectively minimized stigma.

BUILDING CAPACITY FOR EQUITY AND INCLUSION

The experience of being a person who uses drugs is also shaped by an individual's other identities, such as race, ethnicity, gender, sexual orientation, and economic status. Although most of our interviewees believed in the value of racial equity, they expressed frustration in their inability to adequately apply these values to their existing programs and expressed interest in building their capacity to do so. Interviewees also cited the treatment of LGBTQ+ individuals as an important equity concern, especially regarding access to faith-based services and supports that were contingent on adherence to specific rules about sexual activity and expression. Interviewees acknowledged that authentic inclusion and the pursuit of equity require a dedicated commitment to change and ongoing learning. Diversity, equity, and inclusion (DEI) are not a checklist or a set of tasks, but rather require a fundamental mindset shift and ongoing support from seasoned facilitators.

Settlement fund decision-makers should acknowledge the need for education and capacity-building around racial equity and LGBTQ+ equity, as expressed by service providers throughout the state. Additionally, they should identify and provide the facilitated learning processes (training, reflection, and ongoing coaching) needed to develop organizational commitment to diversity, equity, and inclusion. Finally, they can support their members with necessary space and resources to develop equity action plans for their respective organizations and for the settlement fund decision-making coalition itself.

CRITICAL NEEDS FOR HOUSING, TRANSPORTATION, AND EMPLOYMENT SUPPORTS

Our participants overwhelmingly reported the general lack of social supports in their community, including housing, transportation, and employment supports. These needs are especially dire for people who use substances or who are in recovery. For example, past evictions and criminal justice involvement related to substance use may limit affordable housing options as well as the ability to find gainful employment. Additionally, unmet transportation needs can prevent people from engaging with substance use treatment and court re-entry requirements, posing obstacles to employment.

The NC MOA allows the use of funds for recovery housing support (Option A, Strategy 4) and employment-related services (Option A, Strategy 5). Settlement fund decision-makers should build connections with leaders in housing, transportation, and employment supports and include them in strategic planning conversations. These partnerships can lead to shared projects, braided funding, and ultimately enhanced services that benefit people with or in recovery from opioid use disorder and may also be beneficial to the community at large.

MOVING FORWARD: SHARED VISION AND PROGRESS

While our interviews revealed opportunities for thoughtful dialogue around issues that elicit strong feelings from people with divergent perspectives, we identified a shared vision among our participants: saving lives, centering people with lived experience, and improving the quality of life for those with opioid use disorder. This shared vision can provide the common ground on which trust and progress are cultivated.

In support of this vision, the North Carolinians with whom we spoke advised settlement fund decision-makers to include multiple perspectives—especially those from people with opioid use disorder—in their discussions, and to invest in projects that reflect a consensus-driven and evidence-based vision of success. They also emphasized the need for these teams to pursue ongoing and transparent evaluation of selected projects and continuing education related to opioid use disorder, proposed strategies to address substance use, and equity.

Professionals and community members in our state have worked for decades to identify proven strategies and key opportunities for growth. National, regional, and state resources can support settlement fund decision-makers in their assessment of proposed strategies and continued learning. Community members with lived experience of opioid use disorder and substance use can provide invaluable perspectives to this process. This knowledge and collaboration can lead our efforts during this watershed moment in North Carolina.

As we stand here at the start of opioid settlement fund history, North Carolinians have hopes, dreams, and advice for their communities. Community partners across the state are humbled by the challenges ahead, but also view the opioid settlement as a transformative opportunity to build structures and systems that will assist people with a history of substance use in their pursuit of safety, economic stability, meaningful community, health, and well-being.

PURPOSE OF NCIOM'S KEY PERSPECTIVE INTERVIEWS AND FOCUS GROUPS

Between December 2021 and October 2022, the North Carolina Institute of Medicine (NCIOM) spoke with 62 North Carolinians about their perspectives on the current strengths, challenges, and opportunities of substance use education, prevention, and services in communities across our state. **Our objectives were to understand the current challenges faced by people with substance use disorders and the organizations that serve them. Further, we wanted to understand how communities were preparing for the important work of determining how to effectively use new and potentially transformative funding from the settlement of opioid litigation.** This report represents a "snapshot in time" at a critically important moment, when the settlement funding was still very new, but the contours of this opportunity were coming into focus and important decisions and plans were starting to gel.

While these funds are inspiring a renewed dedication to the issue of opioid use disorder, it is important to understand and amplify the perspectives of those who have been directly impacted by the opioid crisis, including those who have supported prevention, crisis response, treatment, and recovery long before the national settlement. These organizations and individuals are acutely aware of the existing strengths, challenges, and opportunities of their respective communities. The participants expertly described existing needs, potential roadblocks, successful strategies, and opportunities for collaboration and growth.

This report describes key findings from the interviews organized across the following themes:

- the implementation of **HARM REDUCTION** strategies
- integrating **SOCIAL SUPPORTS** (such as housing assistance) into treatment programs
- achieving **RACIAL EQUITY** in process and outcomes
- the **MEANINGFUL INCLUSION OF PEOPLE WHO USE DRUGS** in the planning of programs designed for their benefit

Throughout each section, we highlight potential areas of consensus and provide suggested strategies based on our interpretations of ideas expressed by participants. We conclude this report with state leaders' hopes for the future of North Carolinians who use drugs, their loved ones, and their communities.

Across the country, states have taken a variety of different approaches to designing the mechanisms by which national opioid settlement funding will be invested in the programs that work and that will serve the largest number of people for the most good. In North Carolina, the design for the use of settlement funds takes a highly de-centralized approach. The bulk of North Carolina's settlement funding, around 85%, goes directly to cities and counties for investment in strategies outlined in the North Carolina Memorandum of Agreement (NC MOA). This funding design places important decisions and responsibilities in the hands of local communities and their leaders, and ideally will result in investment in high-quality evidence-based programs guided by accountable leaders with direct knowledge of local needs and priorities. More detailed information about the NC MOA is in **Appendix B.**

AWARENESS OF NC MOA

Overall, participants reported a moderate-to-high level of familiarity with the details of the NC MOA, with most reporting greater confidence in explaining Option A than Option B strategies. Under Option A, a county or municipal government may choose one or more strategies from a short list of high-impact strategies to address the opioid epidemic. Under Option B, local governments will complete a collaborative strategic planning process to choose one or more strategies from Option A or from an extended list of strategies included in the national settlement. Many reported that the online publication of the NC MOA document and communications (such as at ncopioidsettlement.org) gave their organizations accessible materials to reference during internal planning discussions.

Individuals who reported a high level of familiarity with the NC MOA attributed their awareness to county meetings and North Carolina Association of County Commissioners (NCACC)/5-5-5 information sessions.[i] Possessing this knowledge was directly related to an organization or individual's relationships with county leaders. Newer organizations—or those that may have conflict with other stakeholders—reported not being as well integrated into information networks that disseminate information about upcoming policy changes or funding opportunities. While county governments may not intentionally exclude key partners in their communications, they should take care not to underestimate the interest of these partners in engaging in strategic planning discussions nor misjudge their relevance to these conversations.

Decision-Making and Accountability

County governments rely on the expertise and experience of health professionals and community leaders. In many counties, leaders have established relationships with substance use prevention coalitions and organizations that serve people who use drugs or who are pursuing recovery. Ideally, these relationships result in community-driven initiatives that benefit all county residents. Newer organizations or people who portray themselves as more removed from "insider" county networks fear that they will not be offered a seat at the table during strategic planning discussions. Some of these individuals shared concerns that their exclusion was politically motivated rather than evidence-based.

Across the board, local partners raised three concerns about funding decision-making:

- Funding opportunities may favor novel "pet projects" rather than investments in existing community partners with a proven track record.
- Large, urban academic or corporate entities may seize this opportunity to institute their own programs in these smaller, more rural and under-resourced communities rather than collaborate with local partners.
- Existing local organizations that do not currently provide substance use services may view the settlement funds as an opportunity to expand their mission but lack relevant expertise and capacity to provide high-quality services.

While participants desire to see their visions for investment come to fruition, they emphasized that no organization or program is entitled to funding. One participant suggested that key partners reconvene periodically throughout the 18-year funding timeline to assess supported initiatives and adjust financial support as needed. This process would also safeguard opioid-related priorities and promote stability through electoral transitions.

SUGGESTED STRATEGIES

Settlement fund decision-makers can foster support for their strategic planning processes by establishing county-level accountability measures. Counties should establish agreed-upon goals and outcome metrics for impact evaluation. These metrics should be transparent and easily accessible to all county residents. Additionally, community partners should decide on when and how often to meet to evaluate progress and adjust strategies as needed.

Other Substance Use Priorities

A few participants described cautious enthusiasm for opioid settlement funding but expressed the perception that their county had "moved on" from the opioid crisis to the stimulant crisis (e.g., methamphetamine and cocaine). Others described different county substance use priorities that include cannabis use as well as youth alcohol and tobacco use.

Some participants emphasized the epidemic of polysubstance use (the use of more than one substance at once) in their counties and described how the opioid crisis and subsequent backlash contributed to the current substance use landscape. Punitive responses to the opioid crisis have led to fewer opioids being available to the public, leaving a "gap in the drug market." According to our participants, this gap has been filled with stimulant drugs.

SUGGESTED STRATEGIES

To ensure that concerns about polysubstance use are addressed during strategic planning, settlement fund decision-makers should learn about the use of multiple substances in their counties and provide education about the connections between different forms of substance use. More "upstream" investments that are not specific to one type of substance can support primary prevention efforts for multiple substances.

[i] *The North Carolina Association of County Commissioners' 5-5-5 Committee is a specially appointed opioid settlement working group created to develop a statewide plan to effectively use North Carolina opioid settlement funds. This committee consists of five county commissioners, five county managers, and five county attorneys from across the state.*

Confusion Related to Option B Strategies

Although all participants understood the variety of Option A strategies in the NC MOA, many had questions about the strategic planning process and the breadth of strategies allowed under Option B. Most people associated Option A strategies with the phrase "evidence-based," resulting in confusion about the degree of "evidence" required for Option B strategies.

SUGGESTED STRATEGIES

Given the appreciation that participants expressed toward the NCACC Option A FAQ resource sheet, similar materials may help community understanding of Option B collaborative strategic planning and additional strategies.

THE ROLE OF RECOVERY

There are various perspectives on the role of recovery as an explicit or implicit goal of programs supported through opioid settlement funding. Differing definitions of recovery and the varying levels of importance assigned to it underline instances of misunderstanding and conflict within substance use coalitions. ***Some define "recovery" as complete sobriety. Others may encourage people who use drugs to define recovery for themselves and promote additional measures of progress in program evaluation: reduced use, preventing the transmission of HCV or HIV, and preventing overdose and death.*** For instance, the experience of an individual who transitions from heavy substance use to occasional substance use may not be captured in traditional definitions of recovery.

SUGGESTED STRATEGIES

Settlement fund decision-makers should initiate strategic planning conversations with thoughtful discussion about the role of recovery and its potential measurement. Common ground can be leveraged to forge agreement on consensus- and values-driven goals and evaluation metrics such as deaths due to opioid overdose, opioid overdose, contact(s) with the criminal justice system, contact(s) with social services, housing and food security, educational and vocational enrollment, and employment.

SHARED VISIONS FOR NORTH CAROLINA: ACCOUNTABILITY

North Carolinians see the opioid settlement as an important opportunity to invest in their communities and expect the development of state- and county-level accountability measures to monitor progress. Although it is nearly impossible to integrate everyone's ideal strategies during the strategic planning process, county leaders can foster partner and community buy-in by promoting trust among diverse sets of decision-makers, transparency in decision-making, and ongoing, publicly accessible evaluation informed by shared definitions of recovery or success.

Stigma exists at multiple levels and often prevents people who use drugs from seeking services. Stigma can come from oneself or others, but it can also be ingrained into institutions through differential policies or protocols based on one's status as a person who uses substances. Throughout the interviews, participants identified stigma as a persistent barrier for people seeking services and treatment for substance use disorder.

LEVELS OF STIGMA AND THEIR IMPACT ON PEOPLE WHO USE DRUGS

Many substance use coalitions and organizations represented in our interviews were founded only in the past two or three decades. Some of the earliest initiatives by these agencies included campaigns challenging the stigma of substance use and addiction, and most participants described a substantial reduction in stigma within their communities over the past 10 years. ***For instance, although protocols mandating first responders to carry naloxone were controversial in the past, no participant reported current widespread antagonism toward naloxone training and distribution to professionals or lay people.***

Participants described the various ways that internalized, interpersonal, and institutional stigma impede those they serve from pursuing treatment or meeting their own recovery goals.

Internalized Stigma[ii]

> ***DESCRIPTION:*** *Internalized stigma occurs when a person with a substance use disorder cognitively or emotionally absorbs negative stereotypes about their condition. They may even begin to believe and apply these negative messages to themselves.*

Participants provided examples of internalized stigma they have seen in their clients. For example, one might believe that their substance use justifies their experience of mistreatment or victimization. In fact, according to our participants, many people they serve express surprise when they are treated with kindness. In extreme circumstances, someone who uses substances may not identify violent behavior as criminal because they expect to experience victimization.

This internalized stigma may remain even once someone meets their recovery or sobriety goals. Some people may insist that substance use treatment should be difficult or painful, rather than supportive and empathetic. An arduous route to recovery and some amount of suffering are perceived as a necessary consequence that one must suffer for their perceived transgression or moral failing (i.e., using illicit substances). These beliefs can not only affect decisions about one's own life, but become more harmful if this mindset guides decision-making about programs supported by settlement funds.

Interpersonal Stigma[iii]

> ***DESCRIPTION:*** *Interpersonal stigma occurs when people direct or enact differential treatment—including verbal harassment and violence—based on an individual's status as someone who uses drugs. Examples of interpersonal stigma include the use of dehumanizing and derogatory terms to refer to people who use substances, the justification of mistreatment or violence against these individuals, and the refusal to support or assist someone based on their substance use disorder.*

Participants relayed stigmatizing interactions that their clients had with family members, health care professionals, social service workers, and law enforcement officers. ***Some clients report forgoing emergency medical care because they did not want to be subject to the stigmatizing treatment of health care workers who perceive them to be irresponsible and drug-seeking.*** Interpersonal stigma especially impacts those who experience other forms of marginalization due to their race/ethnicity or previous contact with the criminal justice system.

Institutional Stigma[iv]

> ***DESCRIPTION:*** *Institutional stigma refers to the institutional and structural conditions, norms, and policies that restrict the resources and hamper the well-being of people who use drugs. Institutional stigma may be enacted through individuals, but the root of it is based in policies and systems.*

Based on our interviews, institutional stigma is the most common form of stigma faced by people who use drugs. ***Even well-meaning individuals within institutions have little ability to change institutional policies that harm people who use substances***. Often, individuals are limited in their capacity to avoid the enforcement of stigmatizing policies because doing so would risk their license or job. In some cases, failing to comply with specific policies may be illegal.

Multiple participants described organizations (medical and social services) whose responses to suspected substance use during pregnancy or parenting dissuaded parents from pursuing treatment or government assistance. Others have learned that their past histories follow them in their medical records. One participant reported that their local hospital's emergency room has different intake protocols for people with and without a history of substance use. If a person has a history of substance use documented in their medical record, they are ushered into a room and are asked to remove every article of clothing (presumably to remove access to substances stored in clothing). This occurs regardless of the reason for seeking emergency medical care.

Additionally, housing policies that deny applications from people with a history of substance use or criminal justice involvement can be counterproductive, as they remove access to a critical support—stable shelter—that has proven to be a significant factor in successful recovery.

ii Definition adapted from: Veterans Health Administration Office of Research and Development (ClinicalTrials.gov NCT01259427)
iii Definition adapted from: Link BG, Phelan JC. Conceptualizing Stigma. Annual Review of Sociology. 2001;27(1):363-385
iv Definition adapted from: American Psychiatric Association ("Stigma, Prejudice and Discrimination Against People with Mental Illness" webpage)

The most-cited form of institutional stigma during our interviews was the lack of disability accommodations in jails and other detention centers for people who need medications for opioid use disorder. When one treatment provider offered its services to its local jail, the response was that jailers treated people going through opioid withdrawal with Gatorade. Despite withdrawal being an unpleasant experience for both incarcerated people and jail workers, the current policies and processes of many jails in our state do not allow for treatment with MOUDs. This is changing, as criminal justice leaders examine their procedures and goals, and improve their facilities' capacity to safely treat opioid use disorder with effective, evidence-based medications.

Some participants reported that stigma can also be directed toward organizations that elevate harm-reduction approaches. Harm reduction is a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use. These approaches include safe injection sites, syringe service programs, naloxone training and distribution, fentanyl test strips, HIV/HCV testing, and opioid treatment programs. Since these strategies do not solely prioritize abstinence and sobriety, some think that harm-reduction organizations enable drug use and fail to address the root causes of substance use disorders. Interviews with some leaders from harm-reduction organizations suggested that this stigma can manifest as exclusion from county and regional discussions on substance use prevention, treatment, and recovery. This is concerning, as harm-reduction strategies have proven to be among the most effective in preventing injury and death.[1-9]

SUGGESTED STRATEGIES

Settlement fund decision-makers should initiate open and honest conversations about internalized, interpersonal, and institutional stigma during the strategic planning process. These conversations are prime opportunities to center the perspectives of those with lived experience of substance use and engage community experts on ways to address stigma.

SHARED VISIONS FOR NORTH CAROLINA: ENCOURAGING HELP-SEEKING

North Carolinians overwhelmingly identify stigma as a key barrier to care. We have successfully overcome stigma in the past through the widespread adoption of naloxone within law enforcement, health departments, social service agencies, schools, and universities. We can use lessons from the past to successfully lead us to a future where individuals are encouraged to ask for help and receive services without shame or stigma.

PERSPECTIVES ON DIFFERENT RECOVERY FRAMEWORKS

It was evident in our interviews that there is a spectrum of attitudes toward abstinence-based and harm-reduction strategies, and most people hold perspectives that include tenets of both frameworks. When individuals have different definitions of success or recovery, they can amplify the effectiveness of their preferred approaches while dismissing the benefits of others. There is also emergent conflict when patient treatment preferences seem to contradict the evidence base. ***The benefits and drawbacks of different strategies and the balance between patient autonomy and evidence-based treatment are important to consider in strategic planning conversations.***

Abstinence-Based Treatment

> ***DESCRIPTION:*** *Abstinence-based treatment refers to the complete cessation of substance use. This philosophy typically assumes that people with substance use disorders are always at risk of returning to use and champions sobriety to remove unnecessary temptation. Examples of abstinence-based treatment philosophies can be found in 12-step programs (Alcoholics/Narcotics Anonymous) and SMART Recovery. Acceptable outcomes for advocates of this approach include abstinence from the specific substance of concern or all substances and the initiation of counseling to address the root causes of addiction.*

Abstinence-based programs provide ample social support, spiritual support, and networks that formally and informally help meet individuals' housing and employment needs. Some of these groups do not endorse the use of medications for opioid use disorder. Some participants see these medications as replacements for illicit substances and "band-aids" that mask deeper issues that should be worked through in therapy. ***Research suggests that while 12-step or abstinence-based approaches may be effective for other substance use disorders, they are far less effective (when used alone) than MOUDs for those with opioid use disorder.***[10-11]

Harm Reduction

> ***DESCRIPTION:*** *Harm reduction refers to a set of strategies and ideas aimed at reducing the negative health, legal, relationship, and financial consequences associated with substance use. Examples of harm reduction approaches include: safe injection sites, syringe service programs, naloxone training and distribution, fentanyl test strip distribution, HIV/HCV testing, and medications for opioid use disorder. Harm reduction strategies are supported by strong evidence that they prevent overdose, transmission of disease, and death. Acceptable outcomes for advocates of this approach include reduction in mortality, reduced and safer use of substances, regular testing for transmissible disease, and initiating opioid treatment.*

Most participants endorsed at least some principles of harm reduction. Strong proponents of harm reduction repeatedly highlight the large evidence base for harm-reduction strategies, including naloxone training and distribution, syringe service programs, and medications for opioid use disorder. They also noted the many federal agencies and professional organizations that endorse harm-reduction strategies: the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the American Medical Association (AMA), and the Association for Addiction Professionals (NAADAC).

However, even those who support certain harm-reduction strategies express apprehension about the widespread use of medications for opioid use disorder for a few reasons. As stated above, many view harm-reduction strategies as enabling maladaptive behavior and being ill-equipped to support people pursuing complete sobriety. Additionally, some people are skeptical of medications for opioid use disorder because the opioid crisis was initiated by pharmaceutical and medication distribution companies. Finally, some participants expressed concerns about overmedicalization of individuals—that people were viewed as "patients with a condition to medicate" rather than a whole person needing support in multiple ways. One participant said that an individual seeking help in a smaller community may feel more supported by the "pastor's wife who runs the church support group" than by the "physician writing a prescription for them under fluorescent lights."

SHARED VALUES AND GOALS

Despite differences in treatment philosophies, the majority of participants believe that people who use drugs should have a variety of treatment options that meet their unique needs. All participants endorsed the importance of "whole person" health and well-being and expressed a sincere desire to address the opioid crisis in their communities. It is important that a variety of perspectives be included in discussions related to opioid settlement funding. If there are professionals who espouse certain views about appropriate treatment, it is likely that there are people who use drugs with those same views. ***This highlights the need to include the diverse perspectives of those with lived experience in strategic planning.***

> ***SUGGESTED STRATEGIES***
> ***Common ground can be leveraged to create consensus- and values-driven definitions, goals, and evaluation metrics. Shared acceptable evaluation metrics for abstinence-based treatment and harm reduction approaches may include deaths due to opioid overdose, opioid overdose, contact(s) with the criminal justice system, contact(s) with social services, housing and food security, educational and vocational enrollment, and gainful employment.***

> ***SHARED VISIONS FOR NORTH CAROLINA: DIVERSE TREATMENT AND EVALUATION OPTIONS***
> ***Despite differences in treatment philosophies, community partners believe that people who use drugs should have a variety of treatment options that meet their unique needs. Most participants strongly endorse the importance of "whole person" health and well-being. All partners should support comprehensive health and social service measures to ascertain progress.***

THE ROLE OF PEOPLE WITH LIVED EXPERIENCE

People with lived experience of substance use include both those who are actively using drugs and those in recovery. All participants who worked with primary prevention or substance use nonprofits reported employing people in recovery—usually incidentally. Only two organizations represented in the interviews reported employing people who actively use drugs. All participants endorsed the importance of peer support in recovery.

Formal and Informal Peer Support

Participants discussed the benefits of both formal and informal methods of peer support. Formal peer support includes employment and/or certification through the North Carolina Peer Support Specialist Program, which requires at least one year of recovery. These mechanisms of support benefit from defined roles with clear boundaries (e.g., job responsibilities) and adequate compensation. ***While participants implied that funders favor formal peer support, they reported that informal peer support provides unique benefits to the community as well***. Informal peer supporters are typically well-known connectors who are not formally affiliated with any organization. They are typically people who actively use drugs and receive substance use services. These individuals are often uniquely skilled at gaining trust with the most marginalized people in their community and connecting them to resources, fostering trust between service-providing organizations and those who may fear seeking services.

Barriers to Employing People Who Use Drugs

Few organizations actively recruit people who use substances, but for many organizations, this is due to organizational barriers rather than a lack of interest in employing them. ***Cited barriers to recruitment and employment include workplace- or insurance-related drug-testing policies, uncertainty about how to support or accommodate people who use substances, and fear of unintentional tokenization or exploitation***. While it is important to consider these factors, one participant said that they accommodate people who use drugs the same way they accommodate every employee's individual needs. They argue that excessive concern about supporting people who use drugs only results in further stigmatization.

SUGGESTED STRATEGIES

Substance use behaviors range widely from person to person; we typically never know our colleagues' relationships with substances. People who use drugs are often stigmatized as irresponsible or dangerous. People pursuing recovery report being patronized or placed on a pedestal, placing unnecessary pressure on them. Approaching individuals with sincere interest and respect can dispel preconceived notions of their abilities, needs, or limitations.

PRIORITIZING EQUITY: CHALLENGES AND OPPORTUNITIES

Some participants also highlighted the significance of representing the diversity of lived experience. One participant described the "most acceptable spokesperson" for the issue of opioid misuse: the mother of the white, male athlete who accidentally overdosed on prescription pills. While it is difficult for mainstream institutions to allow people with lived experience of drug use to speak for themselves, it is also especially challenging for institutions to adequately support the communication of narratives complicated by issues of racism, homophobia, or transphobia. ***Often, the experience of being a person who uses drugs is shaped by an individual's other identities, such as race, ethnicity, gender, sexual orientation, and class***.

Racial Equity

While most organizations acknowledged racial disparities in opioid-related outcomes and endorse the importance of racial equity, few organizations reported that they integrate equity into programming and evaluation efforts. Commonly cited equity-focused strategies include targeted programming to specific communities (e.g., Spanish materials in a Latinx community) and data disaggregation. One organization described a series of advanced strategies: Racial Equity Institute training and evaluation, trauma-informed programming in schools, and inclusion as a listed value. Many participants also highlight equity concerns related to other programs in their community (e.g., law-enforcement-assisted diversion).

Most participants expressed a desire to include equity in their work. However, training and continuing education can be inaccessible to coalitions that are financially constrained or staffed by volunteers. Further, although most participants espouse the value of racial equity, they are unsure of how to apply this value to their existing programs.

SUGGESTED STRATEGIES

Organizational racial equity requires a mindful and dedicated transition from one framework (implicit or explicit racial bias, colorblindness, etc.) to another (racial justice). While it may be tempting to include diversity, equity, and inclusion (DEI) on an ever-growing to-do list, these efforts are more than a set of tasks. For instance, the Government Alliance on Race and Equity uses a model of change that includes four key elements[12]:

- ***VISIONING:*** ***building shared values that move organizations toward racial justice***
- ***NORMALIZING:*** ***building shared understanding through ongoing conversations related to racial equity and inequity; racial justice; structural, institutional, interpersonal, and internalized racism; and implicit and explicit bias***
- ***OPERATIONALIZING:*** ***building tools for decision-making, measurement, and accountability***
- ***ORGANIZING:*** ***building staff and organizational capacity through training and building infrastructure to support the work. This requires building relationships within and across the breadth and depth of organizations and sectors to change the norms, practices, culture, and habits of thought within an organization, producing changes in generated outcomes***

Important readings, trainings, and reflections may be needed to develop organizational commitment. Once this commitment is established, settlement fund decision-makers should support their members with necessary space and resources to develop racial equity action plans for their respective organizations and for the settlement fund decision-making coalition itself.

LGBTQ+ Equity

The treatment of LGBTQ+ individuals is another equity concern among participants, particularly those who provide HCV/HIV testing. For example, many religious recovery housing programs are not inclusive of gay, lesbian, bisexual, or transgender people who use drugs. Sometimes, these programs require that clients sign a statement of faith as a condition of program enrollment.

Many interviewees described making careful recommendations for people seeking services in order to shield them from potential discrimination. For instance, one participant described referring a transgender client to a health clinic based on the primary physician's outward support for LGBTQ+ patients. Unfortunately, many communities do not have multiple sites for accessible opioid treatment. In these cases, participants describe "warning" clients about potential treatment facilities. They expressed tension between not wanting to scare clients and wanting to provide them with complete information that they could use to make decisions about their care.

SUGGESTED STRATEGIES

SAMHSA's Center of Excellence on LGBTQ+ Behavioral Health Equity highlights that LGBTQ+ populations of all ages disproportionately experience more instances of mental health and substance use disorders, suicidality, and poor well-being outcomes compared to their heterosexual and cisgender peers.

Settlement fund decision-makers can begin the pursuit of LGBTQ+ equity by ensuring that funded strategies are affirming to all people, regardless of gender or sexual orientation. Additionally, decision-makers can benefit from a similar strategy to that described above for racial equity. Those participating in strategic planning discussions should understand key concepts and terms related to sexual orientation, gender identity, and gender expression. Leaders in this process should provide the space and resources to pursue the knowledge and tools needed to ensure that discussions and subsequent strategies are affirming to all North Carolinians.

SHARED VISIONS FOR NORTH CAROLINA: INCREASED CAPACITY TO PURSUE INCLUSION

North Carolinians are eager to work with those most directly affected by the opioid crisis—people who use drugs and people who may be disproportionately impacted due to their race, ethnicity, socioeconomic status, or sexual orientation. Individuals express a perceived lack of capacity to support people with substance use disorders and to adequately integrate equity into programming and evaluation. Some community partners are improving their capacity by directly engaging people with lived experience and organizations with expertise to ensure that their programs address equity.

HOUSING SECURITY PROMOTES RECOVERY

Participants supported the strong connection between access to safe, affordable housing and achieving and maintaining recovery. Safe, affordable housing facilitates a variety of goals, making it easier to hold regular employment, get treatment, and maintain a healthy social support network. Housing insecurity can have devastating implications for health and safety. Unhoused people have increased risk of violence due to physical exposure and potential mistreatment by acquaintances offering temporary shelter. For people who inject drugs, the inability to access running water and hygiene products poses barriers to proper wound care. Finally, unhoused people may have to seek shelter in environments that may compromise their recovery goals.

Participants reported a common theme of a lack of affordable housing for all community residents and highlighted that people with a history of substance use face additional barriers to accessing the few options available. For example, past evictions and criminal justice involvement related to substance use disqualify many from already limited subsidized housing. Similarly, few private landlords will accept applications with a poor rental or criminal history.

Some participants also lamented the lack of local recovery housing. Because of barriers in the private market and through public housing programs, some communities set aside financial resources and/or individual housing units that are reserved for people receiving MOUD treatment. Housing support and medical treatment are considered highly complementary, as people with stable housing are more likely to remain in treatment and achieve higher levels of wellness. However, other participants in our interviews did not assign the same importance to recovery housing, arguing that these programs further alienate people who use drugs from the rest of the community.

UNMET TRANSPORTATION NEEDS IMPEDE TREATMENT GOALS

Many participants reported that public transportation in their region is either absent or unreliable. This is especially problematic in regions where people need to cross county lines for treatment. Some health providers reported patients using transportation offered through the Medicaid program to attend medical or counseling appointments. However, using a Medicaid van is a time-consuming process; this is not "point to point" transit, and people may need to account for being away from work or their children for up to an entire business day even if they are attending just one appointment. ***Unmet transportation needs can result in an inability to comply with treatment or court re-entry requirements***. It is difficult to maintain employment without reliable transportation. Missed medical or counseling appointments cause providers to question a patient's dedication to recovery and further fuel stigma. Lapsed medication schedules can also cause physical and mental distress.

SHARED VISIONS FOR NORTH CAROLINA: COMMUNITY RESPONSES TO BARRIERS

Both people who use drugs and those who interact with them have adjusted their decision-making to account for material deprivation. Many participants from a variety of backgrounds in our interviews described the multiple "workarounds" that they developed to manage non-existent or unreliable services. These creative solutions born of necessity are detailed below, and speak to both the ingenuity of the people involved and the unintended consequences that can result from these well-intentioned but often inadequate or inefficient responses to resource constraints.

Clinical Treatment Providers

Treatment providers have responded to transportation needs through the implementation of staggered treatment hours, which are often early and before the typical workday begins. One provider discussed the creation of a voluntary patient carpool board in their office. Finally, providers also engage in formal or informal advocacy, promoting the use of medications for opioid use disorders as members of coalitions or as individuals.

Law Enforcement

Law enforcement officers described holding individuals in jail until local recovery program beds become available or until the facility opens for intake. This presents a serious conflict for law enforcement workers and anti-incarceration advocates alike: the weight of shelter against trauma. While jail workers may perceive incarceration as safer than being unhoused, this is not guaranteed, as many individuals experience violence and medical neglect in jails.

Additionally, to prevent individuals from having criminal records that would preclude them from housing, Sheriff's offices across the state have implemented diversion programs.

Case Managers and Peer Support Specialists

In our interviews, peer support specialists had the most leverage when responding to the needs of people with a history of substance use. They reported using their existing relationships with local business owners and landlords to provide their clients with employment and housing. They also worked to integrate their clients' social networks into discussion sessions to appraise family-level needs and resources and engage loved ones in goal setting. Finally, they facilitated support groups that provided both emotional and informational support, often inviting representatives from local government agencies or nonprofits to speak about their services.

People Who Use Drugs

People who use drugs or who are pursuing treatment often rely on their social networks for housing, transportation, and child care. The quality of these relationships greatly shapes the experiences of those relying on this support. Additionally, many patients find themselves having to prioritize either employment or treatment, since they may need to take full or half-days off from work to adhere to treatment and counseling schedules. Finally, those who cannot attend medical appointments may self-medicate with unprescribed substances.

SUGGESTED STRATEGIES

The NC MOA allows the use of funds for recovery housing support (Option A, Strategy 4) and employment-related services (Option A, Strategy 5). Settlement fund decision-makers should build connections with leaders in housing, transportation, and employment supports and include them in strategic planning conversations. These partnerships can lead to shared projects, braided funding, and ultimately enhanced services that benefit people with, or in recovery from, opioid use disorder and may also be beneficial to the community at large.

In addition to the $750 million from the "Wave 1" settlements (McKesson, Cardinal Health, AmerisourceBergen, Johnson & Johnson), North Carolina stands to receive $600 million in additional funding from "Wave Two" settlements from five additional companies – CVS, Walgreens, Walmart, Allergan, and Teva. These funds will be distributed via a 15-year payment plan beginning in the second half of 2023. These payments will follow the structure outlined in the NC MOA.

While we are near the beginning of the 18 years of settlement funding, North Carolina communities have decades of past experience, data, and research to assist in their decision-making. Despite formidable challenges, they also have hope, and vision:

> *"This is an historic opportunity to leverage funding to save lives in our region, and we are committed to working with communities to increase access to evidence-based practices, such as syringe exchange and medication-assisted treatment, while lifting up the voices of historically marginalized communities and those with lived experience with substance use.*
>
> *We envision a future where everyone in our region has equitable opportunity to live, learn, earn, and thrive, including access to a continuum of effective and affordable services for healing and recovery from opioid-related challenges – not just for individuals but also for entire communities.*
>
> *The NC opioid settlement is a critical step towards that bright future." – April Bragg and Betsey Russel, Dogwood Health Trust*

North Carolina settlement fund decision-makers are supported by a diverse and coordinated community of professionals in research, public health, philanthropy, law, and medicine. Please consult the following resources to learn more about the NC MOA, evidence-based opioid abatement strategies, state and local opioid-related health and community indicators, and the types of assistance available to counties and municipalities.

RESOURCES

- **CORE-NC: Community Opioid Resources Engine for North Carolina**
  Overview: CORE-NC is a collaborative effort from the NC Department of Justice, the NC Department of Health and Human Services, the UNC Injury Prevention Research Center, the NC Association of County Commissioners, and the NC League of Municipalities, with support from the Duke Energy Foundation. This resource serves as a hub of information on the use and impact of opioid settlement funds in North Carolina.
  - Serves as a repository for annual reports and other documents filed by county and municipal governments under the terms of the NC MOA
  - Provides introductory, intermediate, and advanced general and strategy-specific resources
  - Hosts data dashboards related to key opioid indicators, community drivers of health, and the settlement payment schedule

- **North Carolina Association of County Commissioners Opioid Settlement Assistance**
  Overview: The NCACC provides counties with technical assistance related to opioid settlement fund planning and utilization. These supports can help counties manage strategic health initiatives and maximize the impact of funds through outreach, education, and collaboration.
  - Assists counties with strategic action planning, including the prioritization of evidence-based strategies and MOA consultations
  - Facilitates collaboration and connections between county decision-makers, technical experts, and NCACC Strategic Project Coordinators
  - Supports program implementation related to education and training, consultation and coaching, outreach, evaluation and data reporting, and preparation of financial reporting

- **More Powerful NC**
  Overview: More Powerful NC was created by the NC Department of Justice and the NC Department of Health and Human Services to raise awareness of the scope and danger of the opioid crisis in North Carolina.
  - Provides information about Wave 1 and Wave 2 settlements, including links to the full text of the NC MOA as well as to Option A strategies (Exhibit A), Option B strategies (Exhibit B), guidelines for collaborative strategic planning (Exhibit C), and various FAQ pages
  - Includes resources on finding naloxone, syringe service programs, treatment, and recovery support

- **The NC Opioid and Substance Use Action Plan Data Dashboard**
  Overview: The NC Opioid and Substance Use Action Plan (NC OSUAP) Data Dashboard is a website created by the NC Department of Health and Human Services to track state, regional, and county progress toward reaching the goals outlined in the NC OSUAP 3.0.
  - Tracks progress and measures impact through metrics (e.g., counts, percentages, rates) and local actions (e.g., policies and programs) grouped by the following strategy areas: reduce supply, children and families, harm reduction, non-medical drivers, justice-involved populations, treatment and recovery, and equity and lived experience
  - Provides interactive data visualization that allows comparisons over time and between different counties or regions

OVERVIEW OF INTERVIEWS

In 2021, NCIOM staff and state and local experts identified four content areas of interest for the key perspective interviews: harm reduction, working with people who use drugs, racial equity, and social determinants. Emergent topics from initial interviews included stigma, medications for opioid use disorder, abstinence-based approaches, and coalition-building. All of these topics were included in the questions developed for the final interview guide.

NCIOM staff recruited interview participants by contacting individuals from substance abuse coalitions, health programs, and treatment centers across the state. We also used a snowball sampling technique to identify other potential participants. When multiple individuals from the same organization expressed a desire to participate in the key perspective interviews, they were given the opportunity to complete interviews separately or in one focus group together. The interviews were 45 to 60 minutes long and were conducted via Zoom or phone. All interviews took place between December 2021 and October 2022.

Participants and Geographic Representation

In order to capture experiences across affected backgrounds and communities, this report discusses findings from interviews with 62 people from a variety of sectors and geographies. Twenty-seven of these individuals worked in substance use prevention, treatment, and recovery nonprofit organizations. While most of these organizations were non-religious/secular, six of the organizations identified themselves as Christian ministries. Other participants worked in county health departments (7), universities or research centers (5), health care delivery (5), mental health services (5), county government (5), criminal justice and emergency services (5), state government (2), and philanthropic organizations (1). Many of the participants were members of grant-supported or volunteer-supported substance use coalitions in conjunction with or in addition to their occupational roles. **See Table 1.**

Counties from the mountains, piedmont, and coastal plains were represented in our interviews both directly and indirectly. We define direct representation as a participant speaking from their experiencing working in a certain county (e.g., a health department director discussing issues in their county). We define indirect representation as interviews where a participant works in an organization that serves multiple counties (e.g., a program director who is based in one county but oversees services for other counties as well). **See Figure 1.**

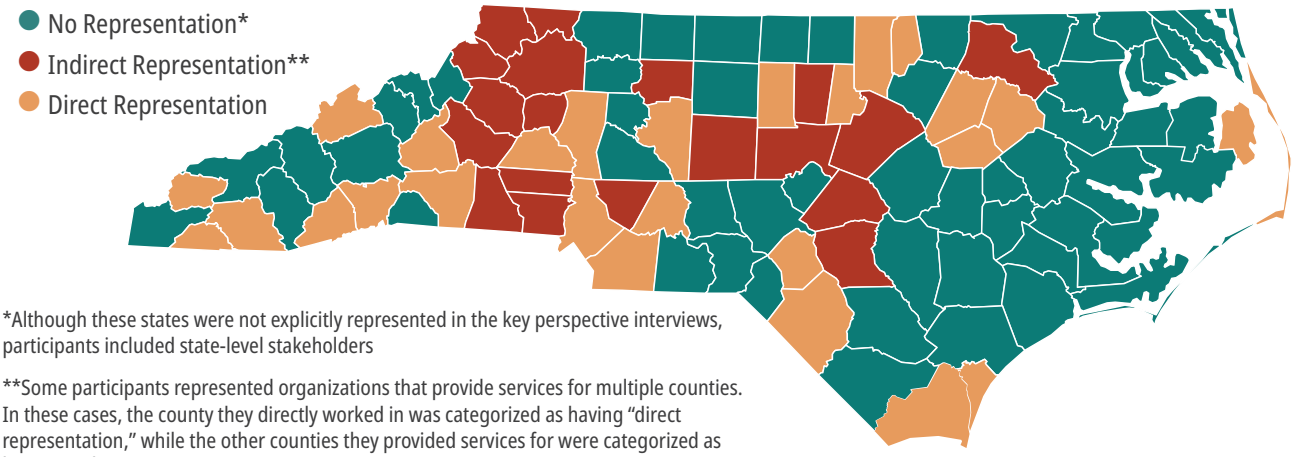
Missing Perspectives: An Opportunity for Ongoing Engagement

While we strove to elicit the full breadth of perspectives among North Carolinians in our interviews, we note that important voices may be missing. For instance, there are a few agencies in our state that offer primarily culturally responsive services (e.g., tribal organizations), but we were unable to make contact with these groups. Additionally, given our recruitment methods, we only spoke with individuals who were formally employed by or associated with substance use organizations or coalitions. It became evident through our interviews that there are citizen leaders throughout our state who connect those in their community to care, and these individuals were not included in our interviews. Finally, we are missing geographic representation from the Southeastern coastal plains and the North Carolina-Virginia border. Despite these gaps, we are confident that our findings are representative of the concerns, challenges, and hopes currently being expressed by those working to combat the opioid crisis across the state. These perspectives may change as settlement funds are distributed and opioid-related outcomes are evaluated. As communities continue to respond to emergent needs, it is important for state experts to continue pursuing opportunities for engagement, partnership, and coordination with local leaders. Future opportunities may build upon our work and include expanded efforts to reach perspectives that are not included in this report.

Table 1. NCIOM MOA Key Perspective Interview Participants by Sector (N=62)

SECTOR	NUMBER OF PARTICIPANTS
Nonprofit Organizations	27
Secular *Nonprofit Organizations*	*21*
Religious *Nonprofit Organizations*	*6*
County Health Departments	7
Universities/Research Centers	5
Health Care	5
Mental Health Services	5
County Government	5
Criminal Justice/Emergency Services	5
State Government	2
Philanthropic Organizations	1

Figure 1. NC Counties Represented in NCIOM Key Perspective Interviews



*Although these states were not explicitly represented in the key perspective interviews, participants included state-level stakeholders

**Some participants represented organizations that provide services for multiple counties. In these cases, the county they directly worked in was categorized as having "direct representation," while the other counties they provided services for were categorized as having "indirect representation."

APPENDIX B: BRIEF OVERVIEW OF THE NATIONAL OPIOID SETTLEMENT IN NORTH CAROLINA

Before we discuss the current landscape of substance use services in North Carolina, it is important to contextualize our present conditions in the broader story of the national opioid crisis and its sequelae. In this chapter, we discuss the origins of the opioid crisis, the health consequences resulting from the proliferation of opioids in legal and illicit markets, and subsequent federal and state government initiatives to address substance use. We conclude with a description of the Memorandum of Agreement Between the State of North Carolina and Local Governments on Proceeds Relating to the Settlement of Opioid Litigation (hereby referred to as the NC MOA for brevity) and NCIOM's activities supporting county and regional planning related to the use of opioid settlement funds.

THE OPIOID CRISIS IN THE UNITED STATES

In the 1990s, Purdue Pharma introduced OxyContin to the medical community.[13] OxyContin was a sustained-release opioid intended to be a revolutionary drug for patients experiencing chronic pain, with pharmaceutical representatives lauding the ways that the sustained-release feature improved safety and efficacy, and, especially, meant that OxyContin had a low potential for addiction.[13] Aggressive marketing tactics and pharmaceutical firm enticements resulted in thousands of physicians prescribing OxyContin and other similar drugs to patients experiencing both acute and chronic pain.[14,15] Subsequent research revealed that, despite the claims from Purdue Pharma, sustained-release opioids did have a high potential for addiction, and many patients who took these medications developed increased tolerance, heightened sensitivity to pain, and substance use disorder.[13,16-17] This laid the groundwork for the contemporary opioid crisis in the United States. By 2015, 91.8 million individuals in the United States used prescription opioids and 1.9 million people had a prescription opioid use disorder.[18]

State governments began to address growing numbers of people addicted to prescription opioids through a variety of measures, including instituting prescription limits, regulating pain clinics, and mandating the use of prescription drug monitoring programs.[19] In turn, people increasingly turned to unregulated substances that were easier to obtain—heroin and, more recently, synthetic opioids like fentanyl—to treat their pain and ward off withdrawal symptoms.[12]

In 1999, approximately 8,000 individuals died from opioid overdose in the United States.[20] By 2016, this number had risen to over 42,000 deaths.[20] In 2017, the United States Department of Health and Human Services declared a public health emergency and unveiled five national priorities to combat the opioid crisis:[21]

1. Improve access to prevention, treatment, and recovery support services
2. Target the availability and distribution of overdose-reversing drugs
3. Strengthen public health data reporting and collection
4. Support cutting-edge research on addiction and pain
5. Advance the practice of pain management

Between 2017 and 2018, the total number of opioid overdose deaths decreased for the first time in at least two decades.[22] However, just as strategic efforts to prevent substance misuse and expand access to treatment began to take effect, the COVID-19 pandemic changed daily life. At the height of the pandemic, individuals lost their jobs, juggled working from home and online schooling for their children, and navigated mass infection and death. In June 2020, 13% of Americans reported starting or increasing substance use as a way of coping with the stress of the pandemic.[23] Additionally, those who were in treatment for substance use disorder experienced disruptions in care as medical facilities reduced face-to-face visits.[24] In 2020, 68,630 individuals died from opioid overdose, with Black Americans and American Indians/Alaskan Natives experiencing the greatest death rate increase among all racial and ethnic groups.[25]

THE OPIOID CRISIS IN NORTH CAROLINA

North Carolina was not spared from the opioid crisis and currently ranks 21st in overdose mortality among all states.[26] Between 1999 and 2017, more than 13,000 North Carolina residents died from unintentional opioid overdose.[27] In 2018, approximately 80% of the state's total drug overdose deaths were due to prescription opioids, heroin, and synthetic opioids.[28] The rate of neonatal opioid withdrawal syndrome in North Carolina is 10.5 per 1,000 hospital births compared to the national rate of 7 per 1,000 hospital births.[29] In 2020, an average of nine North Carolinians died each day from an overdose, a 40% increase from the previous year.[30] In 2021, the rate of opioid overdose deaths among residents was 35.8 per 100,000 residents.[31] **See Figures 2-4.**

Figure 2. Unintentional overdose deaths involving illicit opioids, stimulants, and psychostimulants increased from 2018-2019

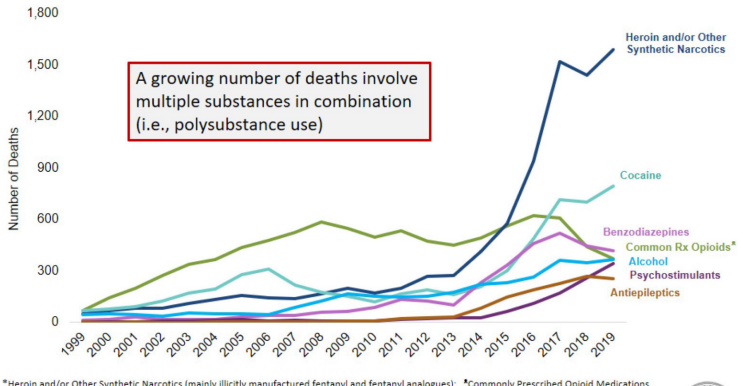
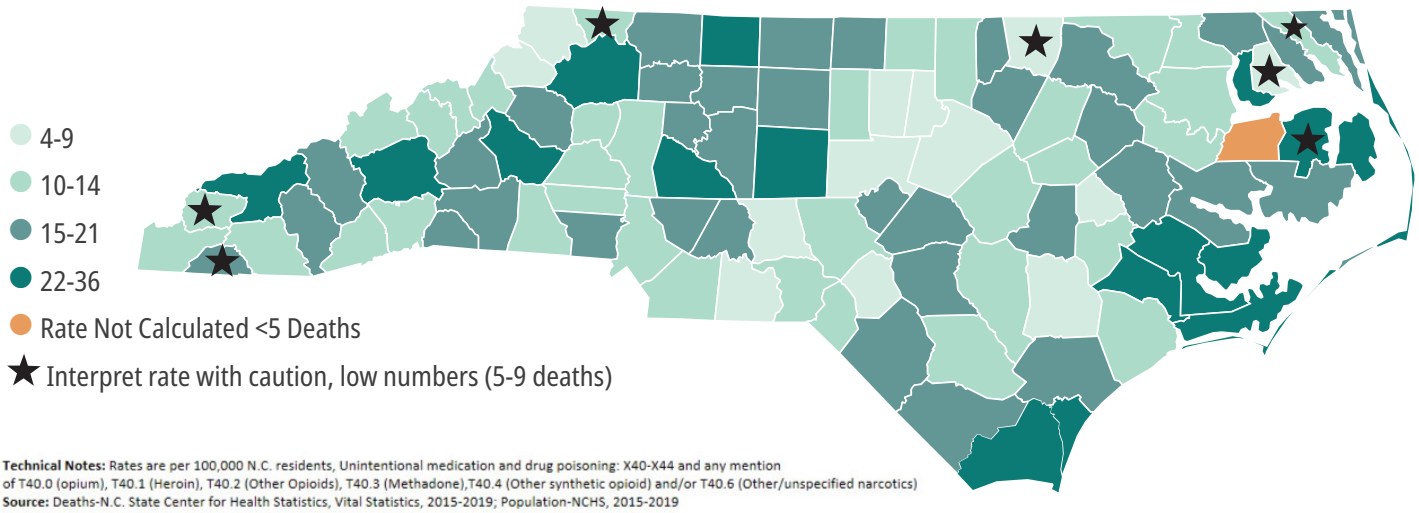
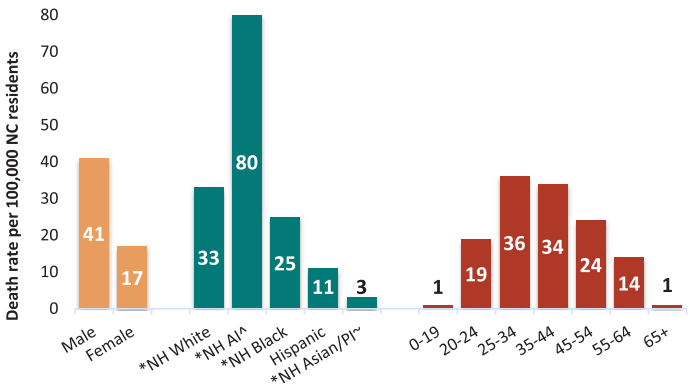


Figure 3. Statewide, the unintentional opioid overdose death rate is 15.3 per 100,000 residents from 2015-2019



Technical Notes: Rates are per 100,000 N.C. residents, Unintentional medication and drug poisoning: X40-X44 and any mention of T40.0 (opium), T40.1 (Heroin), T40.2 (Other Opioids), T40.3 (Methadone),T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics)
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2015-2019; Population-NCHS, 2015-2019
Analysis by Injury Epidemiology and Surveillance Unit

Figure 4. Demographic Snapshot, 2020



- In 2020, the overdose death rate for male decedents was nearly 2.5 times the rate for female decedents.
- American Indians had the highest rate of overdose deaths, almost 2.5 times the rate ofthe next highest group (NH whites). Overdose rates in historically marginalized populations also increased faster than those of NH white people statewide from 2019-2020.
- Fatal overdose rates were highest among adults aged 25-44, and were lowest among those 19 and younger and 65 and older.

**NH:Non-Hispanic ^AI: American Indian ~PI:Pacific Islander (Other/Unknown rate is not reported due to ≤ 10 deaths)*
Demographic data were available for 100% (n=3075) of NC resident overdose deaths recorded in NC-SUDORS for 2020.
Source: N.C. State Unintentional Drug Overdose Reporting System, 2020

Figure 5. North Carolina Opioid Action Plan Across the Years

Version 1.0 (2017)

Focus Areas:
- Create a coordinated infrastructure
- Reduce oversupply of prescription opioids
- Reduce diversion of prescription drugs and flow of illicit drugs
- Increase community awareness and prevention
- Make naloxone widely available and link overdose survivors to care
- Expand treatment and recovery oriented systems of care
- Measure our impact and revise strategies based on results

Version 2.0 (2019)

Wrap-Around Goals:
- Prevent
- Connect to care
- Reduce harm

Objectives:
- Reduce the supply of inappropriate prescription and illicit opioids
- Prevent future opioid addiction by supporting children and families
- Advance harm reduction
- Address non-medical drivers of health and eliminate stigma
- Address the needs of justice involved populations
- Expand access to treatment and recovery supports

Version 3.0 (2021)

Version 2.0 Goals and Objectives
And
Further Wrap Around Goals:
- Track progress
- Measure our impact
- Monitor emerging trends

Updated Priorities:
- Prevent future addiction and address trauma by supporting children and families
- Move beyond just opioids to address polysubstance use
- Increase treatment access for justice-involved people, expand access to housing and employment supports, and recover from the pandemic together

In 2017, Governor Roy Cooper signed the Strengthen Opioid Misuse Prevention (STOP) Act into law. This law limits the number of days' worth of opioids that may be lawfully prescribed upon initial consultation for acute injuries and following surgeries, requires that prescribers use the NC Controlled Substances Reporting System, and requires that physician assistants and nurse practitioners at pain clinics consult with their supervising physicians prior to prescribing opioids.[32] That same year, the NC Department of Health and Human Services launched the first version of the North Carolina Opioid Action Plan, which is now on its third iteration.[31] **See Figure 5.**

The National Opioid Settlement: An Unprecedented Opportunity to Address the Opioid Crisis

In the 2010s, local, state, and tribal governments began pursuing civil litigation against drug manufacturing and distribution companies, claiming that these companies intentionally misrepresented their products.[33] In 2022, North Carolina Attorney General Josh Stein announced that a $26 billion national settlement had been finalized with pharmaceutical distributors—Cardinal, McKesson, and AmerisourceBergen—and Johnson & Johnson.[34] All 100 North Carolina counties and 47 municipalities signed on to the memorandum of agreement, a condition of receiving the maximum settlement payout, entitling the state to $750 million over 18 years. 85% of these funds will go directly to local governments to support prevention, recovery and treatment, harm reduction, and other initiatives to address opioid use disorders in the state.[34] The remaining 15% of these funds will support similar projects at the state level, and spending will be determined by the North Carolina General Assembly.[34] In 2023, additional settlements were completed with other companies; these (and future) settlements will remain aligned to the parameters of the NC MOA.

The North Carolina Memorandum of Agreement

The NC MOA offers counties and municipalities two funding pathways: Option A and Option B. Under Option A, county or municipal governments may find one or more strategies from a short list of high-impact strategies to address the opioid epidemic.[34] Under Option B, local governments will complete a collaborative strategic planning process to choose one or more strategies from Option A or from an extended list of strategies included in the national settlement.[34] Both pathways will offer robust reporting requirements to inform evaluations of the settlement funding decisions. **See Figure 6.**

NCIOM PARTNERSHIPS TO MAXIMIZE THE IMPACT OF OPIOID SETTLEMENT FUNDS

For over 30 years, the North Carolina Institute of Medicine has sought to improve the health and well-being of North Carolinians. One mission of the NCIOM is "to seek constructive solutions to statewide problems that impede the improvement of health and efficient and effective delivery of health care for all North Carolina citizens." We seek to achieve this mission by bringing together task forces to identify evidence-based solutions to health issues, convening and educating health policy stakeholders, publishing the *North Carolina Medical Journal*, and providing non-partisan research and analysis on health and health care.

Early in the settlement process, in partnership with the North Carolina Attorney General's Office and the North Carolina Association of County Commissioners, and with support from the Blue Cross Blue Shield of North Carolina Foundation, the NCIOM created a multi-sector advisory group to support county and regional planning around use of the opioid settlement funds to address substance use disorder and overdose prevention strategies. Through a series of facilitated discussions, participants identified several key coordinating components related to the settlement:

1. Consensus on a fair and effective formula for allocating funds to counties and cities
2. Transparent documentation of spending, activities, and outcomes
3. Strong roadmap for a robust, inclusive county-level planning process
4. Coaching for county-level/city-level planning and implementation
5. Learning collaborative for cross-county collaboration
6. Ability to set rules/guardrails and enforce them
7. Integration of people with lived experience of substance use disorder throughout the planning and implementation

Since July 2021, the NCIOM has initiated several activities in support of these components, including developing a learning collaborative process for county-level stakeholders and convening the leaders of several opioid settlement workstreams to promote coordination and collaboration. In addition, NCIOM has, as part of this work, conducted key perspective interviews with individuals serving communities impacted by substance use. This report identifies key findings from these interviews, as well as related context, in order to inform county-level actions related to the opioid settlements.

Figures 2-5 reprinted with permission from the NC State Center for Health Statistics, NC Department of Health and Human Services.

Figure 6. Option A and Option B Strategies Under the NC MOA

OPTION A

High-Impact Opioid Abatement Strategies [Exhibit A]:

- Collaborative strategic planning
- Evidence-based addiction treatment
- Recovery support services
- Recovery housing support
- Employment-related services
- Early intervention
- Naloxone distribution
- Post-overdose response team
- Syringe service programs
- Criminal justice diversion programs
- Addiction treatment for incarcerated persons
- Re-entry programs

Reporting Requirements:

- Local Spending Authorization Report
- Annual Financial Report
- Annual Impact Report
- Annual Status Survey

OPTION B

Collaborative Strategic Planning Process [Exhibit C]

Option B Report and Recommendations

High-Impact Opioid Abatement Strategies [Exhibit A] and/or

Additional Opioid Remediation Activities [Exhibit B] Related to:

Treatment

A. Treat opioid use disorder
B. Support people in treatment and recovery
C. Connect people to the help they need
D. Address the needs of criminal-justice-involved persons
E. Address the needs of pregnant or parenting women and their families, including babies with neonatal abstinence syndrome

Prevention

F. Prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids
G. Prevent misuse of opioids
H. Prevent overdose deaths and other harms (harm reduction)

Other Strategies

I. First responders
J. Leadership, planning, and coordination
K. Training
L. Research

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