Frequently Asked Questions on Option A Strategies in the Memorandum of Agreement
On the Allocation and Use of Opioid Settlement Funds in North Carolina
Updated October 2023

This document – prepared by the North Carolina Department of Justice – answers questions about the strategies listed in Exhibit A to the Memorandum of Agreement on the allocation and use of opioid settlement funds in North Carolina. Additional resources about each of the strategies is available HERE. Additional information about the opioid settlements is available HERE and HERE. Questions may be directed to opioidsettlement@ncdoj.gov.

Contents

PART 1. COLLABORATIVE STRATEGIC PLANNING

1A. What is the text of the MOA Option A Strategy 1?

The text reads: "**Collaborative strategic planning.** Support collaborative strategic planning to address opioid misuse, addiction, overdose, or related issues, including staff support, facilitation services, or any activity or combination of activities listed in Exhibit C to the MOA (collaborative strategic planning)."

1B. What collaborative strategic planning activities can be funded as part of this strategy?

Under Option A Strategy 1, a local government may fund a wide range of collaborative strategic planning activities (individually or in combination) to address opioid misuse, addiction, overdose, or related issues. These activities may include staff support, facilitation services, or any activity or combination of activities listed in Exhibit C to the MOA. Because a local government may fund any activity or combination of activities listed in Exhibit C, activities listed there that may be funded by the local government include:

- Engaging diverse stakeholders (including those listed on page 2 of MOA Exhibit C)
- Facilitating any planning activities related to opioid settlement funds
- Building upon any related planning efforts to address the opioid overdose epidemic
- Agreeing on a shared vision for the use of opioid settlement funds
- Identifying or reporting on key indicators to determine need or measure progress
- Identifying or exploring root causes of the opioid overdose epidemic
- Identifying or evaluating potential strategies to address the epidemic
- Identifying gaps in existing efforts to address the opioid overdose epidemic
- Prioritizing strategies to address the opioid overdose epidemic
- Identifying or implementing goals, measures, or evaluation plans related to potential or funded strategies to address the opioid overdose epidemic
- Considering ways to align strategies to address the opioid overdose epidemic
- Identifying organizations to implement strategies to address the epidemic
- Developing budgets and timelines for addressing the epidemic

1C. What does it mean to "engage diverse stakeholders" as a collaborative strategic planning activity funded with opioid settlement funds?

To engage diverse stakeholders means to involve a wide array of individuals and organizations in the discussion and planning around opioid settlement funds, including but not limited to these groups listed and described in Exhibit C: (1) local officials, (2) healthcare providers, (3) social service providers, (4) education and employment service providers, (5) payers and funders, (6) law enforcement, (7) employers, (8) community groups, (9) stakeholders with "lived experience," and (10) stakeholders reflecting the diversity of the community.

Please see Exhibit C for additional details.

1D. Does a local government have to undertake ALL of the collaborative strategic planning activities listed in Exhibit C?

It depends whether the local government is proceeding under MOA Option A or Option B.

Collaborative strategic planning under Option A. As explained above, under Option A, a local government may spend opioid settlement funds on any activity listed in Exhibit A. If a local government proceeds under Option A to spend opioid settlement funds on Exhibit A strategy 1 – collaborative strategic planning – the local government may spend opioid settlement funds on any one of the planning activities listed above, or on a combination of such activities, or on all the activities.

Collaborative strategic planning under Option B. Under Option B, a local government undertakes the following steps:

1. The local government engages in ALL the steps of the collaborative strategic planning process described in MOA Exhibit C.
2. The local government drafts a report and recommendations, the contents of which are described in the right-hand column of MOA Exhibit C.
3. The local government formally presents the report and recommendations to its governing body.
4. The local government submits the report and recommendations to the Community Opioid Resources Engine for North Carolina (CORE-NC) within 90 days of the date the report and recommendations were presented to the local governing body, using this link: https://ncopioidsettlement.org/reporting/

Once the report and recommendations have been submitted to the local governing body for consideration, the local governing body may decide to fund one or more strategies from the shorter list of approved strategies listed in MOA Exhibit A or the longer list of strategies from the national settlements in MOA Exhibit B. The local governing body is not required to select the specific strategies recommended in the report and recommendations; they may fund the recommended strategies or other strategies in MOA Exhibit A or B.

By going through ALL the steps of the collaborative strategic planning process that is required for Option B, the local government not only reaps the benefits of thoughtful planning but also opens up a wider array of strategies available to address the epidemic, including the strategies listed in Exhibit A as well as Exhibit B. [MOA § E.5.b & Exhibits B & C]

To see MOA Exhibits and other resources, visit NC DOJ's MorePowerfulNC website at https://www.morepowerfulnc.org and click on Opioid Settlements – NC Memorandum of Agreement.

1E. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

1F. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 2. EVIDENCE-BASED ADDICTION TREATMENT

2A. What is the text of MOA Option A Strategy 2?

The text reads: "**Evidence-based addiction treatment.** Support evidence-based addiction treatment consistent with the American Society of Addiction Medicine's National Practice Guideline for the Treatment of Opioid Use Disorder – including Medication-Assisted Treatment (MAT) with any medication approved for this purpose by the U.S. Food and Drug Administration – through Opioid Treatment Programs, qualified providers of Office-Based Opioid Treatment, Federally Qualified Health Centers, treatment offered in conjunction with justice system programs, or other community-based programs offering evidence-based addiction treatment. This may include capital expenditures for facilities that offer evidence-based treatment for OUD. (If only a portion of a facility offers such treatment, then only that portion qualifies for funding, on a pro rata basis.)"

2B. What is the American Society of Addiction Medicine's national practice guideline for the treatment of opioid use disorder?

The American Society of Addiction Medicine (ASAM) is a professional medical society whose mission is to increase and improve the quality of addiction treatment.[1] ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder is intended to inform and empower clinicians, health system administrators, criminal justice system administrators, and policymakers who are interested in implementing evidence-based practices to improve outcomes for individuals with OUD.[2] In this FAQ, the term "ASAM Guideline" refers to the latest (2020) version of the guideline, available HERE.

[1] American Society of Addiction Medicine (ASAM), "About Us," retrieved HERE in March 2020.
[2] ASAM, "The National Practice Guideline for the Treatment of Opioid Use Disorder – 2020 Focused Update," retrieved HERE in March 2020.

2C. What is opioid use disorder?

In layperson terms, opioid use disorder (OUD) is a chronic brain disease in which a person regularly finds and uses opioids despite the negative things that can happen. OUD is a brain disease because it can change how the brain works. Besides harming a person's health, it can change how someone thinks and feels. This may last a long time, lead to other harmful actions, and cause difficult relationships with family and friends.[3]

In the more clinical terms used by the ASAM Guideline, OUD is a substance use disorder involving opioids. Substance use disorder is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems. Criteria for diagnosing OUD and SUD are provided in the Diagnostic and Statistical Manual of Mental Disorders, version 5 (DSM-5).[4] DSM-5 is the handbook used by health care professionals in the U.S. and much of the world as the authoritative guide to the diagnosis of mental disorders.[5] For more information about OUD, see pages 22-26 of the ASAM Guideline.

2D. What is Medication Assisted Treatment?

Medication Assisted Treatment (MAT) is the treatment of OUD with medication. The ASAM Guideline also uses the terms "pharmacological treatment" and "maintenance medications"[6]; and other authorities use the term "Medications for Opioid Use Disorder" (or MOUD) to refer to medications used to treat OUD.[7]

2E. What medications are used to treat OUD?

There are three medications approved for the treatment of Opioid Use Disorder by the U.S. Food and Drug Administration:

- **Methadone** acts on opioid receptors in the brain to reduce the desire to use the problem drug (such as prescription opioids, heroin, or fentanyl). The patient taking methadone feels normal (not high), and withdrawal does not occur. Methadone can also reduce cravings. Under federal law, methadone must be dispensed through a certified Opioid Treatment Program.
- **Buprenorphine** acts on opioid receptors in the brain to reduce the desire to use the problem drug, which helps the patient avoid withdrawal symptoms. It reduces powerful desires for opioids or cravings.

[3] Adapted from American Society of Addiction Medicine, "Opioid Addiction Treatment: A Guide or Patients, Families and Friends," retrieved HERE in April 2022.
[4] ASAM Guideline, pp. 6-7.
[5] American Psychiatric Association, DSM-5: Frequently Asked Questions, retrieved HERE in April 2022. For more information on the assessment and diagnosis of OUD, see the ASAM Guideline, pp. 22-26.
[6] ASAM Guideline, p. 5.
[7] *See, e.g.,* U.S. Substance Abuse and Mental Health Services Administration, "Treatment Improvement Protocol 63: Medications for Opioid Use Disorder," updated 2021, retrieved HERE in April 2022.

- **Naltrexone** works by blocking opioids from acting on the brain, which takes away the ability to feel the euphoric or sedative effects of opioids.[8] Individuals must be opioid-free for at least 7-10 days before starting to take extended-release naltrexone (known by its brand name, Vivitrol®).

2F. Is Suboxone® the same as buprenorphine?

Suboxone® is a brand-name medication that combines two drugs: buprenorphine and naloxone. Because there are other brand-name and generic medications that combine buprenorphine and naloxone, it is best to use the term "buprenorphine/naloxone" to refer to this class of medications (instead of the brand name Suboxone®).[9]

Buprenorphine is the active drug in buprenorphine/naloxone. As noted above, buprenorphine acts as an opioid in the brain to reduce the desire to use the problem drug, which helps the patient avoid withdrawal symptoms. It also reduces powerful desires for opioids or cravings. Buprenorphine has a "ceiling effect" so the opioid effects level off even with further dose increases, which reduces the risk of misuse of the drug; and naloxone is added to further reduce any potential misuse.[10] (For more about naloxone, see Part 7 below.)

2G. What does the ASAM Guideline say about evidence-based treatment of OUD?

The ASAM Guideline states that "[a]ll FDA approved medications for the treatment of opioid use disorder should be available to all patients"[11] and that "[o]ngoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating opioid use disorder."[12]

2H. Why is MAT the standard of care for OUD?

According to the ASAM Guideline, "[m]edications work quickly to reduce the risk for overdose and overdose death."[13] In addition, "[m]edications work rapidly to restore balance to the brain circuits impacted by addiction, reducing cravings and withdrawal symptoms and enabling patients to address the psychosocial factors that contribute to their disease and establish healthier patterns of behavior to support long-term recovery."[14]

[8] Drug descriptions borrowed from American Society of Addiction Medicine, "Opioid Addiction Treatment: A Guide or Patients, Families and Friends," retrieved HERE in April 2022. For more detailed, precise information reflecting the latest research and clinical recommendations, see ASAM Guidelines, pp. 27-64.
[9] National Alliance on Mental Illness, "Buprenorphine/Naloxone (Suboxone)," retrieved HERE in April 2022.
[10] National Alliance on Mental Illness, "Buprenorphine/Naloxone (Suboxone)," retrieved HERE in April 2022.
[11] ASAM Guideline, p. 32.
[12] ASAM Guideline, p. 35.
[13] ASAM Guideline, p. 27.
[14] ASAM Guideline, p. 27.

2J. Is withdrawal from opioids (detoxification) without the option of MAT an evidence-based treatment for OUD?

No. According to the ASAM Guideline, "[o]pioid withdrawal management (*i.e.,* detoxification) on its own, without ongoing treatment for opioid use disorder, is not a treatment method for opioid use disorder and is not recommended. Patients should be advised about the risk of relapse and other safety concerns, including increased risk of overdose and overdose death. Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating opioid use disorder."[15]

2K. What does the ASAM Guideline mean by "psychosocial treatment"?

As noted above, "[o]ngoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating opioid use disorder."[16] Psychosocial treatment is "any nonpharmacological, professionally administered interventions (*e.g.,* cognitive behavior therapy or insight-oriented psychotherapy) carried out in a therapeutic context at an individual, family, or group level."[17]

2L. Should MAT be denied or delayed in situations where psychosocial treatment is declined or unavailable?

No. While "ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating opioid use disorder,"[18] "a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management."[19]

2M. Are individuals receiving treatment for OUD encouraged to engage in recovery-oriented activities?

Yes. Persons receiving treatment for OUD are encouraged to engage in recovery-oriented activities, including psychosocial interventions – which the ASAM Guidelines defines as "nonpharmacological interventions that may include structured, professionally administered interventions (*e.g.,* cognitive behavior therapy or insight-oriented psychotherapy) or nonprofessional interventions (*e.g.,* self-help groups and non-pharmacological interventions from traditional healers)."[20]

[15] ASAM Guideline, p. 35.
[16] ASAM Guideline, p. 35.
[17] ASAM Guideline, p. 6.
[18] ASAM Guideline, p. 35.
[19] ASAM Guideline, p. 32.
[20] ASAM Guideline, p. 6.

2N. What does the ASAM Guideline say about evidence-based treatment for pregnant women who have OUD?

The ASAM Guideline states that "[p]regnant women with active opioid use disorder should be treated with methadone or buprenorphine as the standard of care."[21] For more information on evidence-based addiction treatment for pregnant women OUD, please refer to pages 49-54 and other relevant pages of the ASAM Guideline.

2P. What is meant by "justice system programs" as that term is used in Option A Strategy 2?

Option A Strategy 2 allows local governments to support evidence-based addiction treatment (as described above) through (among other things) "justice system programs." Such justice system programs may include:

- Pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring substance use disorder or mental health (SUD/MH) condition.
- Pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-based addiction treatment.
- Treatment and recovery courts that provide evidence-based addiction treatment for persons with OUD and any co-occurring SUD/MH conditions.
- Evidence-based addiction treatment for persons who are incarcerated.
- Evidence-based addiction treatment for persons who are leaving incarceration.[22]

It is important to note that Option A Strategy 2 allows local governments to fund evidence-based addiction treatment offered through justice system programs but not other components of those justice system programs.

By contrast, Option A Strategy 10 (criminal justice diversion programs) empowers local governments to "support pre-arrest or post-arrest diversion programs, or pre-trial service programs, that connect individuals involved or at risk of becoming involved in the criminal justice system to addiction treatment, recovery support, harm reduction services, primary healthcare, prevention, or other services or supports they need, or that provide any of these services or supports." As the wording of Strategy 10 indicates, local governments may support evidence-based addiction treatment as well as other components of such programs.

Similarly, Option A Strategy 12 (reentry programs) empowers local governments to "[s]upport programs that connect incarcerated persons to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need upon release from jail or prison, or that provide any of these services or supports." As the wording of Strategy 12 indicates, local governments may support evidence-based addiction treatment as well as other components of such programs.

[21] ASAM Guideline, p. 50.

[22] These categories are derived from the national opioid settlements. *See, e.g.,* the national distributor settlement agreement, Exhibit E, Schedule B, Part D, retrieved HERE in April 2022.

2Q. What does the ASAM Guideline say about evidence-based treatment for persons with OUD who are involved in the criminal justice system?

The ASAM Guideline states that "[a]ll justice-involved individuals, regardless of type of offense or disposition, should be screened for opioid use disorder and considered for initiation or continuation of medication for the treatment of opioid use disorder. Patients with opioid use disorder not in treatment should be assessed and offered individualized pharmacotherapy and psychosocial treatment as appropriate. All FDA approved medications for the treatment of opioid use disorder should be available to patients within the criminal justice system and the treatment plan, including choice of medications, should be based on the patient's individual clinical needs." [23] For more information on evidence-based addiction treatment for persons with OUD who are involved in the criminal justice system, please refer to pages 60-64 and other relevant pages of the ASAM Guideline.

2R. According to the ASAM Guideline, should individuals receiving MAT be forced to stop or change their treatment when they enter the criminal justice system?

No. According to the ASAM Guideline, "[o]pioid use disorder treatment should not be discontinued when individuals become incarcerated."[24] Moreover, "[i]ndividuals entering the criminal justice system should not be subject to forced opioid withdrawal nor forced to transition from agonist (methadone or buprenorphine) to antagonist (naltrexone) treatment. If opioid withdrawal does occur, the patient should be provided withdrawal management services. Patients being treated for opioid use disorder at the time of entrance into the criminal justice system should continue their treatment. Criminal justice staff should coordinate care and access to pharmacotherapy to avoid interruption in treatment."[25]

In addition to the ASAM Guideline, the United States Department of Justice has published guidance on how the Americans with Disabilities Act (ADA) protects people with opioid use disorder (OUD) who are in treatment or recovery, including those who take medication to treat their OUD. The publication, "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery," is intended to help people with OUD who are in treatment or recovery understand their rights under federal law and to provide guidance to entities covered by the ADA about how to comply with the law.[26]

[23] ASAM Guideline, p. 61.
[24] ASAM Guideline, p. 60.
[25] ASAM Guideline, p. 61.
[26] U.S. Department of Justice, "Justice Department Issues Guidance on Protections for People with Opioid Use Disorder under the Americans with Disabilities Act," retrieved HERE in April 2022; U.S. Department of Justice Civil Rights Division, "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery," retrieved HERE in April 2022.

2S. Why is it valuable to provide evidence-based addiction treatment to persons with OUD who are incarcerated or who are being released from incarceration, according to the ASAM Guideline?

> The ASAM Guideline states that "[t]reatment with methadone or buprenorphine while incarcerated results in significant reductions in deaths from overdose in the weeks and months following release from prison. Correctional personnel should collaborate with community-based treatment providers to ensure seamless continuity of pharmacotherapy and psychosocial treatment upon re-entry."[27]
>
> "Risk for relapse and overdose is particularly high in the weeks immediately following release from prison and jails. Patients being treated for opioid use disorder while in prison or jail should be stabilized on pharmacotherapy and continued on treatment after their release. Continuation of treatment after release results in a substantial reduction in all-cause and overdose mortality. Incarcerated individuals with a history of opioid use disorder who are not receiving pharmacological treatment should be assessed for relapse risk prior to reentry. Medications should be initiated a minimum of 30 days before release, and aftercare should be arranged in advance. Patient care on reentry to the community should be individualized and coordinated with treatment providers in the community."[28]

2T. What is an Opioid Treatment Program?

> Option A Strategy 2 allows local governments to support evidence-based addiction treatment (as described above) through (among other things) "Opioid Treatment Programs" – also known as OTPs. An OTP is "[a] program certified by the United States, Substance Abuse and Mental Health Services Administration (SAMHSA), to treat patients with opioid use disorder using methadone. These programs may also offer treatment with buprenorphine and/or naltrexone. An OTP can exist in several settings including, but not limited to, intensive outpatient, residential, and hospital settings."[29] A list of North Carolina OTPs that are members of the North Carolina Association for the Treatment of Opioid Dependence is available HERE.

2U. What is a Federally Qualified Health Center?

> Option A Strategy 2 allows local governments to support evidence-based addiction treatment (as described above) through (among other things) "Federally Qualified Health Centers" – also known as FQHCs. An FQHC is a community-based health care provider that receive funds from the U.S. Health Resources & Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. An FQHC must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.[30]

[27] ASAM Guideline, p. 61.
[28] ASAM Guideline, pp. 61-62.
[29] ASAM Guideline, p. 6.
[30] U.S. Health Resources & Services Administration, "Federally Qualified Health Centers," retrieved HERE in April 2022.

2V. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

2W. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 3. RECOVERY SUPPORT SERVICES

3A. What is the text of MOA Option A Strategy 3?

The text reads: "**Recovery support services.** Fund evidence-based recovery support services, including peer support specialists or care navigators based in local health departments, social service offices, detention facilities, community-based organizations, or other settings that support people in treatment or recovery, or people who use drugs, in accessing addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being."

3A1. What is recovery?

The ASAM Guideline defines "recovery" as "a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence [as that term is defined below], addressing impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process."[31]

In this context, the ASAM Guideline defines "abstinence" as "intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors. . . . Use of FDA approved medications for the treatment of substance use disorder is consistent with abstinence."[32]

[31] ASAM Guideline, p. 6.
[32] ASAM Guideline, p. 3.

While helpful, the ASAM definition is not the only possible definition of recovery (and the ASAM Guideline itself notes that "ASAM continues to explore, as an evolving process, improved ways to define recovery").[33]

3A2. Do all of the strategies listed after the word "including" serve as examples of "evidence-based recovery support services" that local governments may fund under Option A strategy 3?

Yes. All of the strategies listed after the word "including" serve as examples of "evidence-based recovery support services" that local governments may fund under MOA Option A strategy 3. Thus, evidence-based recovery support services that local governments may fund under MOA Option A strategy 3 include "peer support specialists or care navigators based in local health departments, social service offices, detention facilities, community-based organizations, or other settings that support people in treatment or recovery, or people who use drugs, in accessing addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being."

3B. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

3C. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 4. RECOVERY HOUSING SUPPORT

4A. What is the text of MOA Option A Strategy 4?

The text reads: "**Recovery housing support.** Fund programs offering recovery housing support to people in treatment or recovery, or people who use drugs, such as assistance with rent, move-in deposits, or utilities; or fund recovery housing programs that provide housing to individuals receiving Medication-Assisted Treatment for opioid use disorder."

[33] ASAM Guideline, p. 6.

4A1. Do the first and second clauses of Option A Strategy 4 each stand on their own as separate options that local governments may fund?

Yes. The first clause of Option A Strategy 4 ("Fund programs offering recovery housing support to people in treatment or recovery, or people who use drugs, such as assistance with rent, move-in deposits, or utilities") and the second clause of Option A Strategy 4 ("fund recovery housing programs that provide housing to individuals receiving Medication-Assisted Treatment for opioid use disorder") each stand on their own as separate (though related) options that a local government may fund.

4A2. Under the first clause of Option A Strategy 4, may a local government fund recovery housing programs?

Yes. Under the first clause of Option A Strategy 4 ("Fund programs offering recovery housing support to people in treatment or recovery, or people who use drugs, such as assistance with rent, move-in deposits, or utilities"), a local government may fund recovery housing programs.

4A3. Under the first clause of Option A Strategy 4, may local governments fund recovery housing programs that do not serve persons who are using FDA-approved medications for opioid use disorder (methadone, buprenorphine, and/or naltrexone)?

While the language of Option A Strategy 4 does not preclude a local government from funding such programs, local governments and any entities they fund must comply with relevant laws and rules, including laws that prohibit discrimination against people with substance use disorder such as the Americans with Disabilities Act (42 U.S.C. §§ 12131-12165 & 12181-12189) and Fair Housing Act (42 U.S.C. §§ 3601-3631). Local governments should consult their attorneys to ensure compliance with such laws.

4B. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

4C. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 5. EMPLOYMENT RELATED SERVICES

5A. What is the text of MOA Option A Strategy 5?

The text reads: "**Employment-related services.** Fund programs offering employment support services to people in treatment or recovery, or people who use drugs, such as job training, job skills, job placement, interview coaching, resume review, professional attire, relevant courses at community colleges or vocational schools, transportation services or transportation vouchers to facilitate any of these activities, or similar services or supports."

5B. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

5C. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 6. EARLY INTERVENTION

6A. What is the text of MOA Option A Strategy 6?

The text reads: "**Early intervention.** Fund programs, services, or training to encourage early identification and intervention for children or adolescents who may be struggling with problematic use of drugs or mental health conditions, including Youth Mental Health First Aid, peer-based programs, or similar approaches. Training programs may target parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, or others in contact with children or adolescents."

6A1. What population must early intervention programs focus on?

Option A Strategy 6 allows local governments to "Fund programs, services, or training to encourage early identification and intervention for children or adolescents who may be struggling with problematic use of drugs or mental health conditions."

The phrase "children or adolescents who may be struggling with problematic use of drugs or mental health conditions" means individuals under the age of 26[34] in one of these situations:

[34] Although experts define the terms "children" and "adolescent" in various ways depending on the context, NC DOJ is not aware of any such definition of the terms "children" or "adolescents" that includes individuals over the age of 25.

(1) they are struggling with problematic use of drugs or mental health conditions; or

(2) they "may be" struggling with problematic use of drugs or mental health conditions, meaning there is some objective reason to believe they are at risk of struggling with problematic use of drugs or mental health conditions. For example, a person who has experienced Adverse Childhood Experiences (ACEs) has an elevated risk of struggling with problematic use of drugs or mental health conditions.[35]

In sum, to qualify as an early intervention program under Exhibit A Strategy 6, a local government strategy must focus on individuals under the age of 26 who are struggling with – or at risk of struggling with – problematic use of drugs or mental health conditions.

6A2. If a local government wishes to fund training programs in connection with this strategy, what types of training programs may be funded?

Under Exhibit A Strategy 6, "Training programs may target parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, or others in contact with children or adolescents." While the immediate audience for such training programs may be parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, or others in contact with children or adolescents, the focus and purpose of the training programs must be to identify or assist individuals under the age of 26 who are struggling with – or at risk of struggling with – problematic use of drugs or mental health conditions, as explained in question 6A1 above.

6A3. Does a general prevention strategy that discourages drug use throughout an entire population qualify as "early intervention" under Exhibit A Strategy 6?

No. A general prevention strategy that discourages drug use throughout an entire population (such as a local jurisdiction, school district, or neighborhood) does not qualify as "early intervention." In order to qualify as "early intervention" under Exhibit A Strategy 6, the strategy must focus on identifying or assisting individuals under the age of 26 who are already struggling – or at risk of struggling – with problematic use of drugs or mental health conditions. Because a general prevention strategy does not focus on this specific population, it does not qualify as "early intervention" under Exhibit A Strategy 6.

Local governments interested in funding general prevention strategies may wish to consider the strategies listed in Exhibit B, including one or more of the strategies listed in Exhibit B Section G ("Prevent Misuse of Opioids"). As a reminder, in order to fund a strategy that is listed in Exhibit B but not listed in Exhibit A, a local government must follow all of the requirements associated with MOA Option B.

[35] "A growing body of work within the field of ACEs focuses on its intersection with substance use disorders (SUDs). ACEs are positively correlated with substance use and SUD risk in adulthood." Centers for Disease Control and Prevention, "Adverse Childhood Experiences, retrieved HERE in October 2023.

6A4. Does a general prevention strategy that discourages drug use among all children or adolescents (with no specific focus on children or adolescents who are struggling – or are at risk of struggling – with problematic drug use) qualify as "early intervention" under Exhibit A Strategy 6?

No. A general prevention strategy that discourages problematic drug use among all children or adolescents (with no specific focus on children or adolescents who are struggling – or are at risk of struggling – with problematic drug use) does not qualify as "early intervention." In order to qualify as "early intervention" under Exhibit A Strategy 6, the strategy must focus on identifying or assisting individuals under the age of 26 who are already struggling – or at risk of struggling – with problematic use of drugs or mental health conditions. Because a general prevention strategy that discourages drug use among all children or adolescents does not focus on this specific population, it does not qualify as "early intervention."

6B. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

6C. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 7. NALOXONE DISTRIBUTION

7A. What is the text of MOA Option A Strategy 7?

The text reads: "**Naloxone distribution.** Support programs or organizations that distribute naloxone to persons at risk of overdose or their social networks, such as Syringe Service Programs, post-overdose response teams, programs that provide naloxone to persons upon release from jail or prison, emergency medical service providers or hospital emergency departments that provide naloxone to persons at risk of overdose, or community-based organizations that provide services to people who use drugs. Programs or organizations involved in community distribution of naloxone may, in addition, provide naloxone to first responders."

7B. What is naloxone?

Naloxone is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist. This means that it attaches to opioid receptors and reverses and blocks the effects of other opioids. Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.[36]

7C. Is Narcan® the same as naloxone?

Narcan® is a brand name for naloxone, just as Kleenex® is a brand name for facial tissue and Xerox® is a brand name for copy machine. When naloxone was first approved to reverse opioid overdoses, its brand name was Narcan®. Now there are other formulations and brand names for naloxone. Although some people continue to call all of these products Narcan®, the proper generic name for these overdose-reversal drugs is "naloxone."[37]

7D. How is naloxone given?

Naloxone should be given to any person who shows signs of an opioid overdose or when an overdose is suspected. Naloxone can be given as a nasal spray or it can be injected into the muscle, under the skin, or into the veins. Naloxone currently comes in two FDA-approved forms: injectable and prepackaged nasal spray.[38]

7E. Who can distribute naloxone?

North Carolina law states that naloxone may be distributed by "[a] governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors"[39] in keeping with certain legal requirements described in the law. The website naloxonesaves.org offers detailed information on how community organizations and others can distribute naloxone in North Carolina.

7F. Is naloxone a treatment for opioid use disorder (OUD)?

No. Naloxone is a medicine that rapidly reverses an opioid overdose. By contrast, as explained in Part 2 above, methadone, buprenorphine, and naltrexone are medications used to treat opioid use disorder.[40]

7G. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

[36] National Institute on Drug Abuse, "Naloxone Drug Facts," retrieved HERE in April 2022.
[37] National Institute on Drug Abuse, "Naloxone Drug Facts," retrieved HERE in April 2022.
[38] National Institute on Drug Abuse, "Naloxone Drug Facts," retrieved HERE in April 2022.
[39] North Carolina General Statutes, section 90-12.7(c1), retrieved HERE in April 2022.
[40] National Institute on Drug Abuse, "Naloxone Drug Facts," retrieved HERE in April 2022.

7H. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 8. POST-OVERDOSE RESPONSE TEAM

8A. What is the text of MOA Option A Strategy 8?

The text reads: "**Post-overdose response team.** Support post-overdose response teams that connect persons who have experienced non-fatal drug overdoses to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being."

8B. What is a post-overdose response team?

A post-overdose response team (or PORT) engages with a person who has experienced an overdose and seeks to link the patient with appropriate care that may include harm reduction services, treatment, recovery support, or primary healthcare. Other terms for a PORT are quick response team, community response team, or rapid response team.[41]

8C. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

8D. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

[41] North Carolina Department of Health and Human Services, "Overdose Epidemic: First Responders," retrieved HERE in April 2022.

PART 9. SYRINGE SERVICE PROGRAM

9A. What is the text of MOA Option A Strategy 9?

The text reads: "**Syringe Service Program.** Support Syringe Service Programs operated by any governmental or nongovernmental organization authorized by section 90-113.27 of the North Carolina General Statutes that provide syringes, naloxone, or other harm reduction supplies; that dispose of used syringes; that connect clients to prevention, treatment, recovery support, behavioral healthcare, primary healthcare, or other services or supports they need; or that provide any of these services or supports."

9B. What is a Syringe Service Program?

A Syringe Service Program (SSP) provides sterile syringes and naloxone, disposes of used syringes, provides educational materials, connects clients to treatment and other services, and complies with North Carolina General Statutes, section 90-113.27.[42]

9C. Who can operate an SSP?

Any governmental or nongovernmental organization, including a local or district health department or an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, may establish or operate an SSP.[43] All SSPs operating in North Carolina are required to register with and submit annual reports to the North Carolina Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention Branch.

9D. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

9E. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

[42] North Carolina General Statutes, section 90-113.27, retrieved HERE in April 2022;
[43] North Carolina General Statutes, section 90-113.27, retrieved HERE in April 2022;

PART 10. CRIMINAL JUSTICE DIVERSION PROGRAM

10A. What is the text of MOA Option A Strategy 10?

The text reads: "**Criminal justice diversion programs.** Support pre-arrest or post-arrest diversion programs, or pre-trial service programs, that connect individuals involved or at risk of becoming involved in the criminal justice system to addiction treatment, recovery support, harm reduction services, primary healthcare, prevention, or other services or supports they need, or that provide any of these services or supports."

10B. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

10C. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 11. ADDICTION TREATMENT FOR INCARCERATED PERSONS

11A. What is the text of MOA Option A Strategy 11?

The text reads: "**Addiction treatment for incarcerated persons.** Support evidence-based addiction treatment, including Medication-Assisted Treatment with at least one FDA-approved opioid agonist, to persons who are incarcerated in jail or prison."

11B. What are FDA-approved opioid agonist medications?

"Opioid agonist medications pharmacologically occupy and activate opioid receptors in the body. They thereby relieve withdrawal symptoms and reduce or extinguish cravings for opioids.[44] Methadone and buprenorphine are the two FDA-approved opioid agonist medications used to treat opioid use disorder."[45]

11C. Why is it valuable to provide evidence-based addiction treatment to persons with OUD who are incarcerated?

Please see questions 2P, 2Q, 2R, and 2S above.

[44] ASAM Guideline, p. 5.
[45] ASAM Guideline, p. 6 (definition of "opioid treatment services").

11D. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

11E. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

PART 12. REENTRY PROGRAMS

12A. What is the text of MOA Option A Strategy 12?

The text reads: "**Reentry Programs.** Support programs that connect incarcerated persons to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need upon release from jail or prison, or that provide any of these services or supports."

12B. Why is it valuable to provide evidence-based addiction treatment to persons with OUD who are being released from incarceration?

Please see questions 2P, 2Q, 2R, and 2S above.

12C. Where can I find resources related to this strategy?

General resources related to this strategy are available on the North Carolina Opioid Settlements Resources page.

12D. Who can help better understand or implement this strategy?

You may contact the North Carolina Association of County Commissioners at opioidsettlement@ncacc.org or DHHS at opioidsettlement@dhhs.nc.gov with questions about strategies to address the opioid overdose epidemic. If you have not done so, you may also wish to reach out to your local health department or any local coalitions addressing substance misuse or related issues.

APPENDIX ONE: ACRONYMS USED IN THIS DOCUMENT

ASAM = American Society of Addiction Medicine.
DSM-5 = Diagnostic & Statistical Manual of Mental Disorders.
FDA = Food and Drug Administration.
FQHC = Federally Qualified Health Center.
HRSA = Health Resources & Services Administration.
MAT = Medication Assisted Treatment.
MH = Mental Health.
MOA = Memorandum of Agreement.
MOUD = Medications for Opioid Use Disorder.
OUD = Opioid Use Disorder.
OTP = Opioid Treatment Programs.
PORT = Post Overdose Response Team.
SAMHSA = Substance Abuse & Mental Health Services Administration.
SUD = Substance Use Disorder.
SSP = Syringe Service Program.

APPENDIX TWO: GLOSSARY OF TERMS USED IN THIS DOCUMENT

Abstinence = The ASAM Guideline defines "abstinence" as "intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors. . . . Use of FDA approved medications for the treatment of substance use disorder is consistent with abstinence."[46]

American Society of Addiction Medicine (ASAM) = A professional medical society whose mission is to increase and improve the quality of addiction treatment.

Agonist medications = Medications that occupy and activate opioid receptors in the body, thereby relieving withdrawal symptoms and reducing or extinguishing cravings for opioids.

Antagonist medications = Medications that attach to opioid receptors and reverses and blocks the effects of other opioids.

Buprenorphine = An opioid agonist medication that acts as an opioid in the brain to reduce the desire to use the problem drug. Buprenorphine helps patients avoid withdrawal symptoms and reduces powerful desires for opioids.

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) = The handbook used by health care professionals in the U.S. and much of the world as the authoritative guide to the diagnosis of mental disorders.

[46] ASAM Guideline, p. 3.

Federally Qualified Health Center (FQHC) = A community-based health care provider that receives funds from the U.S. Health Resources & Services Administration (HRSA) to provide primary care services in underserved areas. An FQHC must provide care on a sliding fee scale based on ability to pay and must operate under a governing board that includes patients.

Medication Assisted Treatment (MAT) = The treatment of Opioid Use Disorder with FDA approved medication such as methadone, buprenorphine, or naltrexone.

Methadone = An opioid agonist medication that acts as an opioid in the brain to reduce the desire to use the problem drug.

Naloxone = A short-acting opioid antagonist medication that can reverse an opioid overdose.

Naltrexone = an opioid antagonist medication that blocks opioids from acting on the brain, taking away the ability to get high from using opioids.

Narcan® = A brand name for the drug naloxone.

Opioid = A term for any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and synthetic / semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their action.

Opioid Treatment Program (OTP) = A program certified by the United States, Substance Abuse and Mental Health Services Administration (SAMHSA) to treat patients with opioid use disorder using methadone. Programs may also offer treatment with buprenorphine and/or naltrexone. An OTP can exist in several settings including, but not limited to, intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.

Opioid Use Disorder (OUD) = A substance use disorder involving opioids.

Post Overdose Response Team (PORT) = A team that engages with a person who has experienced an overdose and seeks to link the patient with appropriate care that may include harm reduction services, treatment, recovery support, or primary healthcare.

Psychosocial treatment = Any nonpharmacological, professionally administered interventions carried out in a therapeutic context at an individual, family, or group level. Examples include cognitive behavior therapy or insight-oriented psychotherapy.

Recovery = The ASAM Guideline defines “recovery” as “a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence [as that term is defined below], addressing impairment in behavioral control, dealing with cravings, recognizing problems in one’s behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self

and others. The concepts of humility, acceptance, and surrender are useful in this process."[47] In this context, the ASAM Guideline defines "abstinence" as "intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors. . . . Use of FDA approved medications for the treatment of substance use disorder is consistent with abstinence."[48] While helpful, the ASAM definition is not the only possible definition of recovery (and the ASAM Guideline itself notes that "ASAM continues to explore, as an evolving process, improved ways to define recovery").[49]

Suboxone = A brand-name medication that combines buprenorphine and naloxone.

Substance Use Disorder (SUD) = A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems.

Syringe Service Program (SSP) = A program that provides sterile syringes and naloxone, disposes of used syringes, provides educational materials, connects clients to treatment and other services, and complies with North Carolina General Statutes, section 90-113.27.

[47] ASAM Guideline, p. 6.
[48] ASAM Guideline, p. 3.
[49] ASAM Guideline, p. 6.