SUPPORTING DECISION MAKERS USING OPIOID SETTLEMENT FUNDS

Glossary of Terms

JULY 2024

PREVENTION INSTITUTE

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PREVENTION INSTITUTE is a national nonprofit whose mission is to build prevention and health equity into key policies and actions at the federal, state, local, and organizational level to ensure that the places where all people live, work, play, and learn foster health, safety, and wellbeing.

This resource was developed by Prevention Institute. It was overseen by Dana Fields-Johnson, Director, and written by Amanda Gao, Senior Program Assistant and Juan González, Associate Program Manager. Additional support and review was provided by Madison Do Linh, Program Coordinator; Claudia Sanchez-Lopez, Associate Program Director; and Sheila Savannah, Managing Director.

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INTRODUCTION

Just as our understanding of the opioid epidemic has evolved over time, so has the language used to describe the contributing factors, people, challenges, impacts, and solutions associated with it. **This glossary is meant to synthesize expert-authored definitions for terms Prevention Institute (PI) and its project partners have identified as important for understanding, planning for, and implementing activities using opioid settlement funding as of July 2024.** PI recognizes that this list is not comprehensive and that additional independent research—including direct conversations with practitioners, people with lived and living experience, and local experts on this issue—might be required, particularly to provide localized context for settlement fund decision-making. PI also encourages practitioners to continuously vet these definitions against the latest and best language practices, especially in the face of an ever-changing epidemic with disproportionate impacts (e.g., by geography, specific population).

DEFINITIONS

Settlement fund background

Abatement fund

"Abatement fund" typically refers to a fund or statutory trust set aside specifically and exclusively for future opioid remediation (any remediation expenses for future interventions that states cannot use to reimburse themselves for past opioid remediation expenditures) and that is appropriated separately from a state's general funds.[1] Based on the terms of the settlement agreement, states are required to spend 70% of their national settlement funds on prospective abatement interventions (*e.g.,* those listed in Exhibit E documentation).[2] State abatement funds often hold this money devoted to future interventions separately from those that can be spent with fewer restrictions.

Exhibit E - List of opioid remediation uses

This attachment to national settlement documents provides a "non-exhaustive list of expenditures that acts as a guideline for how each state should prioritize its spending." Exhibit E identifies several core strategies to prioritize and additional approved uses for settlement funds. Each settlement document includes its own version of Exhibit E, though core strategies and approved uses are essentially the same across all versions. For example, see the Exhibit E document from the Teva settlement. Through their states' memoranda of understanding, "several states have published additional lists of priorities to identify particular subsets of interventions it would like to lift above the rest."[3]

Opioid epidemic in the U.S.

Opioid-related overdoses have led to many deaths in the U.S— between 1999-2021, nearly 650,000 people died from an opioid-related overdose. According to the CDC, there have been three distinct waves of opioid-related deaths related to different types of opioids throughout the last 25 years: (1) prescription opioid overdose deaths, (2) rise in heroin, and (3) rise in synthetic opioids other than methadone. Many opioid-involved overdoses also include other drugs, including but not limited to other opioids, stimulants, and xylazine (See definition for "Polysubstance use"). The latest data on fatal drug overdoses can be found in CDC's State Unintentional Drug Overdose Reporting System.[4]

For over forty years, the U.S. federal government has spent trillions of dollars in efforts to enforce the criminalization of drugs it has deemed illicit through a set of laws and actions termed The War on Drugs. Drug use and overdose rates have not declined during this period.[5,6] Present-day policies, including those that increase penalties for offenses involving specific drugs such as fentanyl, allocate opioid settlement funds to law enforcement personnel, and

resist expanded access to evidence-based treatment and harm reduction strategies, extend a harmful legacy of prioritizing criminal punishment.[7,8,9]

The opioid epidemic in the U.S. has often been portrayed in media and public reporting as a crisis affecting rural, White communities. However, the crisis has disproportionately affected Black, Indigenous, and people of color (BIPOC) communities, and increasingly so since the onset of the COVID-19 pandemic. Research shows a demographic shift in the epidemic, with dramatic increases in opioid misuse and overdose deaths observed among Hispanic/Latino, African American, and American Indian/Alaska Native populations since 2020.[10] People of color are more likely to face criminal justice involvement (see definition for "Substance use-related harms") relating to drug use and face barriers when accessing treatment and recovery services, including racism and stigma.[11,12]

A specific cause of the opioid crisis in the U.S. and globally is hard to establish. Experts and research suggest that some contributing factors to overdose deaths include the influence and aggressive marketing of pharmaceutical companies; misinformed prescribing practices; poor policy decisions (such as maintaining barriers to existing treatment); and criminalization (leading to fear of asking for help during an emergency and increased overdoses in jails and prisons).[13,14,15] Elements in the community environment that create community trauma, such as poverty, lack of economic opportunity, displacement, and limited access to social support systems, can also be drivers of substance misuse. For more information on how a community trauma-informed approach can support substance-use response, see the definition for "Continuum of opioid and other substance use prevention" and this profile from Prevention Institute.

Opioid remediation efforts

Based on Exhibit E documentation (see separate definition), 85% of a state's funds from the "national" or "global" settlement must be allocated towards opioid remediation activities such as treatment, harm reduction, prevention, recovery services, training, and research. Remediation is defined in the settlement agreement as "Care, treatment, and other programs and expenditures (including reimbursement for past such programs or expenditures except where this Agreement restricts the use of funds solely to future Opioid Remediation) designed to (1) address the misuse and abuse of opioid products, (2) treat or mitigate opioid use or related disorders, or (3) mitigate other alleged effects of, including on those injured as a result of, the opioid epidemic."[16,17]

Opioid settlement fund

Mentions of the opioid settlement or opioid settlement funds typically refer to the "national" or "global" opioid settlement that started reaching states in 2022 and will be disbursed over several years. The 2021 national settlements resolved litigation against three pharmaceutical distributors (McKesson, Cardinal Health, and AmerisourceBergen), amounting to $21 billion paid over 18 years, and pharmaceutical manufacturer Janssen, amounting to $5 billion paid over up to nine years. The 2022 National Settlements were also finalized against pharmacy retailers (CVS, Walgreens, and Walmart) and manufacturers (Allergan and Teva). As of May 2024, settlement amounts and payment schedules towards local and state political subdivisions for the 2022 National Settlements are still being finalized. Updates can be found on the National Opioids Settlement website (nationalopioidsettlement.com).[18,19] In combination with other ongoing settlements against opioid manufacturers, distributors, and retailers, an expected $50+ billion will be awarded to state and local jurisdictions and more than $1.5 billion to

tribal communities across the United States.[20] The amount of settlement funding and appropriate uses for funding flowing from states to local jurisdictions depends on each participating state's settlement spending plan.

Substance use-related harms

Addiction

According to the American Society of Addiction Medicine, addiction is a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. Those who experience addiction may use substances repetitively, often despite harmful consequences. Prevention and treatment is as successful for addiction as for other chronic diseases (see definition for "Continuum of opioid and other substance use prevention").[21] A variety of either environmental or biological risk (e.g., adverse home environments, community poverty) and protective factors (e.g., parental support, neighborhood resources) influence the risk of addiction.[22]

Adverse community experiences (ACEs) and resilience and community trauma

Exposure to interpersonal violence and structural violence, often a result of discriminatory policies and practices that inflict harm on communities, is an Adverse Community Experience (ACE). Adverse Community Experiences contribute to trauma at both the individual and community level. Symptoms of community trauma include, but are not limited to, intergenerational poverty, disconnected social networks, low political and social efficacy, and unhealthy public spaces. Community trauma compromises community characteristics in a way that increases their likelihood of being risk factors for multiple forms of violence (see definition for "Risk and protective factors"). Focusing on community protective, or resilience, factors such as social networks and trust, healthy community design, and living wages and local wealth, helps reduce the risk of individual and community trauma, and as a result, the risk of violence.

Criminalization of substance use is considered a form of structural violence that contributes to community trauma and increases the impact of other risk factors for further substance use and multiple forms of violence. Thus, a response focused on the criminalization of substance use, rather than community healing and resilience, can in and of itself perpetuate substance use.[23,24]

Drug-related harms

Harms related to substance use or responses to substance use can occur beyond the physical health risk of overdose and overdose deaths and can manifest at either the individual or systems level. For example, there has been an increase in blood-borne infectious diseases such as viral hepatitis, HIV, and bacterial and fungal infections among people who inject drugs, including opioids.[25] Syringe services programs is an evidence-based strategy that helps reduce the spread of infectious disease for people who inject drugs (see definition for "Harm reduction").

U.S. federal drug policy has historically focused on controlling drug supplies through prohibition, over-policing, arrest, and mass incarceration (see definition for "Opioid epidemic in the U.S."). Drug-related arrests disproportionately impact poor people and people of color and create barriers to receiving a job, education, housing, and more.[26,27] The criminalization of substance use is an example of structural violence, or an adverse community experience (ACE), that contributes to community trauma.[28] Such trauma is a risk factor for continued substance use (see definition for "Risk and protective factors" and "Adverse community experiences (ACEs) and resilience and community trauma").

Substance use

Substance use refers to the use of selected substances, including alcohol, tobacco products, drugs, inhalants, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body with possible dependence and other detrimental effects.[29] Other terms, such as "drug use" would refer specifically to the use of drugs, including opioids.

- **Substance use disorder (SUD)** is defined as a problematic pattern of substance use leading to clinically significant impairment or distress. Education and awareness around the harm of using substances, along with the support of friends, parents, community members, and caregivers, can help prevent SUDs.[30]
- **Opioid use disorder (OUD)** is a medical condition characterized by the continuing use of opioids that causes clinically significant distress or impairment. Treatment for OUD, including medication, is safe and effective (see definition for "MOUD"). OUD and misuse of opioids are different from the safe, effective use of prescription opioids for controlling and reducing pain.
- **Polysubstance use** occurs when two or more drugs are taken together. According to the CDC, intentional polysubstance use occurs when a person takes a drug to increase or decrease the effects of a different drug or wants to experience the effects of the combination.

  Unintentional polysubstance use occurs when a person takes drugs that have been mixed or cut with other substances, like fentanyl, without their knowledge.[31] Opioid-involved overdoses often occur in combination with exposure to other opioid or non-opioid substances.
- **Substance misuse** may refer to the use of prescription medications other than when safely used as prescribed. This can occur unintentionally. Substance misuse may also refer to the use of substances the federal government has classified as illicit, such as heroin and methamphetamine.[32]

Strategies to address opioid and substance use

Continuum of opioid and other substance use prevention

Opioid settlement funds provide a valuable opportunity for decision makers to make strategic investments that address the full continuum of opioid and other substance use—whether an individual has yet to be exposed to opioids and other substances or is actively navigating a disorder (Figure 1). Historically, decision makers have largely invested in secondary and tertiary prevention strategies as a means to address the immediate harms of the epidemic. However, in order to enact sustainable community change and prevent further harm from occurring, decision makers should also consider how to prioritize primary prevention and focus on the structural determinants that lead individuals to use.[33]

Figure 1. Continuum of Opioid and Other Substance Use Prevention.

- **Primary prevention:** Primary prevention strategies and solutions are those that address community-level changes intended to reduce opioid and other substance exposure and use and prevent use disorders in the first place. For example, primary prevention could include a concentrated focus on social isolation that leads to worsened experiences of depression and anxiety; medical misinformation that leads to overprescription of opioid medications; a high geographic concentration of unhealthy retail establishments like pain clinics and alcohol outlets; and general community deterioration, economic despair, and hopelessness that can intensify opioid dependence. Primary prevention strategies and solutions center on community healing and resilience, recognize that there is no one-size-fits-all approach to solving the opioid epidemic, and leverage community wisdom in fostering change.
- **Secondary prevention:** Secondary prevention strategies and solutions are those that focus on treating escalating use and misuse of opioids and other substances. For example, secondary prevention could include harm reduction strategies (see definition for "Harm reduction") and improved access to treatment, clinical support, and awareness and anti-stigma (see definition for "Stigma") campaigns for individuals at high risk for opioid misuse and use disorder (*e.g.,* those with complex health conditions and/or a job loss or disruption).
- **Tertiary prevention:** Tertiary prevention strategies and solutions are those that are implemented after the onset of substance and opioid use disorder, and seek to prevent overdoses and deaths, repeat emergency room visits, and family disruptions through the child welfare system. Tertiary prevention could include treatment for opioid use disorder (see definition for "MOUD"), rapid response and street outreach teams, and naloxone distribution.

Harm reduction

Harm Reduction International defines harm reduction as "policies, programs, and practices that aim to minimize the negative health, social, and legal impacts associated with [substance] use, policies, and laws." This framework and set of strategies aims to keep people who use and misuse substances alive, encourage positive change in their lives, and offer alternatives to approaches that seek to prevent or end substance use and misuse. Harm reduction services include information on safer substance use, MOUD (see separate definition), needle and syringe programs, overdose prevention and reversal (*e.g.,* naloxone), legal services, and drug checking.[34] Harm reduction strategies have been shown to substantially reduce HIV and hepatitis C infection among people who inject substances, reduce overdose risk, and increase the likelihood of initiating treatment for substance use disorder.[35] The National Harm Reduction Coalition has identified eight foundational principles for implementing harm reduction, which are described on its website.

Long-term recovery

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "a

process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." SAMHSA outlines four major dimensions of recovery, including health, home, purpose, and community (see SAMHSA's website for more details). Recovery from substance and opioid use and misuse is often a long-term process that could include medical treatment (see definition for "MOUD"), behavioral therapies, and recovery support services (*e.g.,* case management, peer support, and substance-free housing). More information on evidence-based treatment and recovery strategies can be found in this report from the Legal Action Center.

Medication for Opioid Use Disorder (MOUD)

Medication for Opioid Use Disorder (MOUD) refers to the class of medications that are approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder (OUD), and includes buprenorphine, methadone, and naltrexone. Depending on the specific medication used, MOUD reduce cravings for opioids and/or block their euphoric and sedative effects. MOUD are often used as a tool for long-term recovery (see separate definition), along with counseling and behavioral therapies.[36] However, as a result of regulatory barriers, low prescribing practices and pharmacy availability, and stringent federal and state policies related to opioids, access to MOUD has been historically restricted.[37,38,39] For more information on the evidence behind MOUD and potential treatment strategies, please refer to this report from the Legal Action Center.

Recurrence of opioid and other substance use

A recurrence of opioid and other substance use—sometimes referred to as the less preferred, more stigmatizing term "relapse"—happens when a person in recovery stops maintaining their goal of reducing or avoiding use of substances and returns to previous levels of use. During a recurrence, a person in recovery could be at higher risk for overdose compared to when they first began to use due to changed physical tolerance to a substance. The causes for recurrence are often very personal, but could include social circumstances that act as a trigger for opioid and substance use as a coping strategy (*e.g.,* insecure housing, social stigma, traumatic event) and emerging or pre-existing physical and mental health issues.[40]

Risk and protective factors

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), **risk factors** for opioid and substance use disorders are "characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative [health] outcomes." Examples of risk factors for opioid and substance use disorders include adverse childhood experiences (ACEs, including parental substance use exposure), unemployment and other lack of economic opportunity, and neighborhood violence. **Protective factors**, on the other hand, are "characteristics associated with a lower likelihood of negative [health] outcomes or that reduce a risk factor's impact," such as strong community networks, policies limiting the availability of alcohol and other substances, and availability of after-school activities. Effective prevention strategies focus on reducing the risk factors and strengthening the protective factors that most impact a specific community. People do not exist in isolation, so it is imperative that opioid response strategies address risk and protective factors across multiple contexts (*e.g.,* individual relationships, communities, society) for maximum impact.[41]

Engagement and health equity

Community engagement

Community engagement is an ongoing process of developing relationships with people with lived and living experience (see definition for "PWLLE") and other community members impacted by the opioid epidemic to work together to identify, plan, and implement solutions. Rather than a set of standard steps to follow, community engagement processes should be tailored to the challenges, opportunities, talents, relationships, and resources that exist within a specific community.[42] The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified seven core principles of community engagement, which are described in greater detail in their practice guide:

- Transparency and trust
- Careful planning and preparation
- Inclusion and demographic diversity
- Collaboration and shared purpose
- Openness and learning
- Impact and action
- Sustained engagement and participatory culture

Evidence based decision-making

According to the CDC, evidence based decision-making is a "process for making decisions about a program, practice, or policy that is grounded in the best available research evidence and informed by experiential and contextual evidence."[43] The decision-making process—which can be applied to opioid settlement fund and response strategies—typically involves gathering, interpreting, and applying what is learned from these three layers of evidence, which are described in greater detail below.[44,45]

- **Best available research evidence:** Best available research evidence is produced through scientific inquiry and process, and typically includes published, peer-reviewed material. According to the CDC, "the more rigorous a study's research design, the more compelling the research evidence, indicating whether or not a program, practice, or policy is effectively preventing [a public health issue]."
- **Experiential evidence:** Experiential evidence describes the experiences and expertise of those who have lived, learned, worked, and played in a particular setting and/or experienced the negative consequences of a public health issue, such as the opioid epidemic (see definition for "PWLLE"). This type of evidence is accumulated over time and can be identified through interviews, community meetings, communities of practice, and focus groups.
- **Contextual evidence:** Contextual evidence refers to information about whether or not a prevention strategy "fits" within the local, historical, resource, and/or social context in which it would be implemented. This information could include measurable factors collected from localized community data sources (*e.g.,* census and administrative data, needs and assets assessments) and histories (*e.g.,* surveys, focus groups).

Health equity

Achieving health equity means that everyone has a fair and just opportunity to attain their full health potential, especially people who have experienced present or historical structural disadvantage or exclusion (*e.g.,* Black, Indigenous, people of color; people with disabilities; women; people who are LGBTQIA+; immigrants; people with opioid use disorder; *etc.*).[46,47,48] Health equity can take on many forms within a community, including:[49]

- **Procedural equity:** Transparent, fair, and inclusive processes that provide additional opportunities for groups who have been or are disproportionately impacted. This includes acknowledging power imbalances and engaging people who have experienced health inequities in decision-making processes (see definition for "PWLLE").
- **Distributional equity:** The fair distribution of resources, benefits, and burdens across a community, with prioritization of resources for groups experiencing the greatest inequities. Distributional equity is informed by quantitative and qualitative data that speaks to how, where, and to whom goods, services, and other resources should be allocated.
- **Structural equity:** Addresses underlying structural factors and policies that give rise to inequities in the first place, and represents a commitment to correcting past harms and preventing future unintended consequences. Within this framework, inequities are often reversed through some combination of new equitable norms, policies, and/or representation.

For more information on how to integrate health equity concepts into responses to the opioid epidemic, please see this digital resource library from the National Association of County & City Health Officials.

People with lived and living experience (PWLLE)

People with lived and living experience (PWLLE) are those directly affected by the negative consequences of the opioid epidemic and the strategies that aim to address it. PWLLE could include people who have used ("lived experience") or currently use ("living experience") opioids and other drugs and their affected friends and family members. The unique insights of PWLLE into the personal histories, barriers, and opportunities that describe the opioid epidemic make them necessary partners in deciding how settlement funds are used.[50] The U.S. Department of Health and Human Services recommends that agencies "work with [PWLLE] to develop a deeper understanding of the conditions affecting certain populations, the solutions that are most appropriate for those impacted by the issue, and the potential harmful unintended consequences of the current and past actions taken by the existing system on the people it aims to serve."[51]

Public health approach

A public health approach to addressing the opioid epidemic is rooted in the scientific method but recognizes a need to consider the unique community conditions that contribute to and protect from opioid misuse and injury (see definition for "Social determinants of health"). This approach—which should complement, not replace, evidence-based treatment strategies for opioid use and misuse—recognizes the value in partnership and collective planning between multi-sector experts, such as medical professionals, researchers, advocates, legislators, PWLLE (see separate definition), and community-based organizations.[52] Prevention Institute defines the public health approach as including the following characteristics:[53]

- Advances health (the physical, mental, and spiritual condition that allows people to thrive and live fulfilling lives), safety (freedom from violence and the threat of violence), and wellbeing (reflected in vibrant mental and behavioral health) at the community and population level;
- Insists on health equity and racial justice (see separate definitions) as the drivers for social transformation by acting on the structural factors and systems that shape opportunities for health, safety, and wellbeing;
- Focuses on entire communities and their sociocultural, economic, and physical environments rather than on one individual at a time; and
- Prioritizes upstream prevention (see separate definition) whenever possible by addressing problems as close to their source as possible and taking action before illness or injuries occur.

Racial justice

Racial justice is the systematic fair treatment and empowerment of people of all racial and ethnic identities. Achieving racial justice requires reconciling past and present histories of racial trauma, the redistribution and sharing of power and resources towards excluded racial and ethnic groups, and the elimination of policies and practices that create differential outcomes between White and non-White people. Emerging racial inequities in opioid use disorder and death rates (see definition for "Opioid epidemic in the US") are rooted in structural racism—racial bias across institutions and society—and therefore, responses to the epidemic need to be rooted in racial justice principles, cultural humility, and intentional engagement.[54,55]

Social determinants of health

According to the CDC, social determinants of health (SDOH) are the community conditions in which people live, learn, work, and play. This includes the economic policies and systems, social norms, political systems, and built environments that shape daily life, also known as **upstream SDOH,** because they often function as fundamental causes of poor health and inequities. SDOH have been shown to have a greater influence on health outcomes than genetic factors or access to healthcare resources and should be a prominent focus of primary prevention strategies (see definition for "Continuum of opioid and other substance use prevention").[56] Examples of social determinants of health that can influence rates of substance and opioid use and misuse include employment, housing, and education, but may differ depending on specific community conditions.[57]

Stigma

Stigma can include public stigma—negative social attitudes and norms towards people who use substances, such as those circulated by mass media—and structural stigma—systems-level discrimination, such as by the criminal justice system, that limits if and how people who use substances can access resources, opportunities, and general wellbeing. Many people mistakenly believe that opioid and substance addiction is a result of poor individual discipline and decision-making when, in reality, research has identified it as a treatable chronic disease attributed to multiple biological and environmental factors.[58] Stigma has been shown to negatively impact treatment-seeking behaviors among people who use opioids and other substances and can further perpetuate social isolation.[59] The National Institute on Drug Abuse (NIDA) recommends moving away from stigmatizing language that assigns negative labels to people (*e.g.,* addict, junkie) and towards person-first language that emphasizes the individual rather than their diagnosis or condition (*e.g.,* person with a substance use disorder).[60] Additional person-first terms can be found on the NIDA website.

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Prevention Institute

221 Oak Street

Oakland, CA 94607

preventioninstitute.org