

Primer on Spending Funds from the Opioid Litigation

A Guide for State and Local
Decision Makers



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Executive Summary



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

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

These nine core abatement strategies¹ are:

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

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

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

Background

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

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

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

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

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

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

Core Strategy 1

Broaden access to naloxone

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

What is evidence around the use of naloxone?

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

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

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

Who should carry naloxone?

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

How important are naloxone trainings?

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

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

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

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

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

Core Strategy 2

Increase use of medications to treat opioid use disorder

The settlements state that funds should be used to:

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

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

What are the medications used to treat opioid use disorder?

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

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

What other services help people in treatment and recovery?

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

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

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

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

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

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

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

How can jurisdictions use litigation money to improve treatment options?

Jurisdictions should fund programs that:

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

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

Core Strategy 3

Provide treatment and supports during pregnancy and the postpartum period

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

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

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

Particular considerations for OUD treatment during pregnancy include:

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

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

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

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

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

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

Jurisdictions should fund programs that:

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

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

Core Strategy 4

Expand services for neonatal opioid withdrawal syndrome

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

What are the impacts of neonatal opioid withdrawal syndrome?

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

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

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

What should health systems do?

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

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

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

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

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

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

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

Core Strategy 5

Fund warm hand-off programs and recovery services

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

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

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

How do warm hand-offs work?

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

Who can benefit from warm hand-offs?

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

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

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

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

Jurisdictions should fund:

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

Core Strategy 6

Improve treatment in jails and prisons

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

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

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

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

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

How are these programs administered?

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

What about diversion concerns?

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

What about programs that provide alternatives to incarceration?

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

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

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

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

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

Core Strategy 7

Enrich prevention strategies

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

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

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

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

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

How should jurisdictions use litigation money to improve prevention programs?

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

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

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

Core Strategy 8

Expand harm reduction programs

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

How do syringe services programs help address the opioid epidemic?

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

What are other evidence-based harm reduction services?

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

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

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

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

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

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

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

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

Core Strategy 9

Support data collection and research

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

Why is data collection and program evaluation important?

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

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

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

Jurisdictions should fund:

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