PRONTO Study

Partnerships for Post-Overdose Outreach

Best Practice Guidance for Post-Overdose Outreach

JANUARY 2023

Boston Medical Center

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Grayken Center for Addiction

Boston Medical Center

Brandeis

THE HELLER SCHOOL FOR SOCIAL POLICY AND MANAGEMENT

OPRC

Opioid Policy Research Collaborative

Members of the Panel

Ricky Bluthenthal	University of Southern California Keck School of Medicine
Michael Botticelli	Former Director, White House Office of National Drug Control Policy, Obama Administration
Corey Davis	Harm Reduction Legal Project, Network for Public Health Law
Alexandra Duncan	The Pew Charitable Trusts
Kathryn Hawk	Yale University Department of Emergency Medicine
Haner Hernández	New England Addiction Technology Transfer Center at Brown University
Ayana Jordan	New York University Grossman School of Medicine
Tara Kunkel	Rulo Strategies
Mike Lawlor	University of New Haven Henry C. Lee College of Criminal Justice and Forensic Sciences
Sasha Mital	Centers for Disease Control and Prevention
Joanne Peterson	Learn to Cope
Daniel Raymond	National Viral Hepatitis Roundtable
Sharon Stancliff	AIDS Institute, New York State Department of Health

PRONTO Research Team

Traci C. Green, PhD, MSc, Opioid Policy Research Collaborative, Heller School for Social Policy and Management at Brandeis University

Scott Formica, PhD, Social Science Research & Evaluation

Sarah Bagley, MD, Boston University School of Medicine, Boston Medical Center, Grayken Center for Addiction

Jennifer J Carroll, PhD, MPH, North Carolina State University

Ziming Xuan, ScD, SM, Boston University School of Public Health

Leo Beletsky, JD, MPH, Northeastern University School of Law

David Rosenbloom, PhD, Boston University School of Public Health

Robert Apsler, PhD, Social Science Research & Evaluation

Emily Cummins, PhD, Boston Medical Center, Grayken Center for Addiction

Shapei Yan, MPH, Boston Medical Center, Grayken Center for Addiction

Audrey Lambert, MPH, Boston Medical Center, Grayken Center for Addiction

Haley Cinq-Mars, MPH, Boston Medical Center, Grayken Center for Addiction

Owen Cheung, BA, Boston Medical Center, Grayken Center for Addiction

Alexander Y. Walley, MD, MSc, Boston University School of Medicine, Boston Medical Center, Grayken Center for Addiction

Additional Information

This project was funded by the Centers for Disease Control and Prevention (R01CE003052). To learn more about the study and associated publications, please visit: reporter.nih.gov/project-details/10003108

To learn more about this and future research, please visit: prontopostoverdose.org

To learn more about opioid policy research, please visit:heller.brandeis.edu/opioid-policy

Suggested Citation:

Best Practice Guidance for Post-Overdose Outreach. Boston, MA: Grayken Center for Addiction, Boston Medical Center; www.prontopostoverdose.org. January, 2023.

PRONTO Study
Partnerships for Post-Overdose Outreach

Best Practice Guidance for Post-Overdose Outreach

Table of Contents

Introduction

Aim

To create evidence-informed best practice guidance for post-overdose outreach programs useful to agencies that create, lead, manage, or fund post-overdose outreach programs nationwide with the goal of reducing the risks of subsequent overdose.

Background

There is an urgent need to address rising opioid overdose rates in the United States

The United States faces escalating rates of opioid overdose; approximately 500,000 people died from an opioid-related overdose from 1999 to 2019.[1] The number of opioid-related overdose deaths in the United States increased 90% from 2013 to 2017, largely due to the proliferation of illicitly manufactured fentanyl in the drug supply.[2] In the midst of the COVID-19 pandemic, overdose deaths in the United States exceeded more than 100,000 for the first time in the 12-months ending in April 2021.[3] Increases in overdose deaths since 2019 have disproportionately occurred among American Indian, Alaskan Native, Black, Hispanic and Latino people.[4–8] Nonfatal opioid overdose is a major risk factor for a subsequent fatal opioid overdose, and the period immediately following a nonfatal overdose presents a potential, but frequently missed, opportunity for intervention.[9–13]

Post-overdose outreach programs have emerged as one potential strategy to reduce future overdose risk among overdose survivors.

Among many responses to address escalating overdose deaths, post-overdose outreach programs have emerged across the United States.[14–17] Post-overdose outreach programs engage overdose survivors and/or their social networks (family, friends, and close acquaintances) in the days following an overdose to connect survivors with a variety of services and strategies, to reduce their risk for future overdose. Typically, post-overdose outreach programs obtain information about overdose events involving interactions with emergency service responders from emergency service calls (e.g., 911). Programs usually offer referral and linkage to locally available treatment for substance use disorder (SUD),[18,19] and many adopt a harm reduction approach to preventing overdose and other harms of substance use through naloxone distribution, provision of safer drug use supplies, and connection to community services that address health-related social needs such as food, shelter, and employment. [20,21]

Many-existing post-overdose outreach programs have been initiated by local law enforcement agencies responding to local surges in overdose with access to 911 call data.[17,22–28] Funding for post-overdose outreach programs has largely come from state and federal agencies that have recognized these programs as a potential overdose response strategy warranting further exploration.[29–31] The Office of National Drug Control Policy (ONDCP), Bureau of Justice Assistance (BJA), the U.S. Centers of Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA) have supported public health-public safety partnerships through investments and resources.

Public safety agencies, especially law enforcement, commonly take the lead in providing emergency service call data to identify survivors and partner with public health agencies to provide post-overdose outreach services

In many communities, law enforcement agencies have taken the lead in developing post-overdose outreach programs and obtained funding to sustain such programs. These public safety agencies have filled a void in public health capacity and infrastructure for post-overdose outreach. The participation of law enforcement officers in post-overdose outreach efforts often represents a substantial departure from traditional law enforcement work, as officers may engage in community health and behavioral health activities; become familiar with and work collaboratively with health and social service agencies, harm reduction organizations, and treatment programs; and focus on the public health goal of reducing overdose mortality and morbidity. For some agencies, post-overdose outreach was the next step in addressing the overdose crisis after equipping themselves with naloxone and receiving training on overdose recognition and response.[23]

Post-overdose outreach programs have emerged in the midst of systemic stigmatization and criminalization of people who use drugs, particularly those who are American Indian, Alaskan Native, Black, Hispanic or Latino. In studies of interactions between law enforcement and people who use drugs, many people report disrespectful conduct by police, confiscation of personal property, medications, and other important items, and even violence.[32,33] People who identify as American Indian, Alaskan Native, Black, Hispanic and Latino are disproportionately arrested, incarcerated,[34,35] and killed by law enforcement,[36–42] compared to people who identify as White. The history and current experiences of American Indian, Alaskan Native, Black, Hispanic and Latino people who use drugs[43,44] with law enforcement and the courts can challenge the ability of post-overdose outreach programs to engage many people who are at highest risk of overdose.

Most programs utilize teams of both public health and public safety (most often law enforcement) personnel to conduct outreach visits. [14,16,17,20,25,28] The extent and type of collaboration between public health and public safety in these programs takes a range of forms, from public safety only providing 911 call data for outreach by a public health-staffed team[17] to public safety agencies conducting the outreach without any public health partner involvement. Public health personnel, as used in this context, is broadly inclusive of anyone working or volunteering in the community to promote health and wellness, such as behavioral health personnel, recovery coaches, harm reduction staff, community health workers, and clergy.[14,21,28,45].

In order to function, post-overdose outreach programs must receive identifying contact information of overdose survivors. Privacy restrictions applicable to identifiable data held by certain health care organizations impact the ability of healthcare partners to share data with post-overdose outreach programs. Specifically, emergency medical service (EMS) providers must comply with the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule, which constrains their ability to share information about the patients they treat. However, most law enforcement agencies are not subject to HIPAA and therefore do not have the same privacy restrictions on the information they share.[46]

Post-overdose programs have emerged as public safety-public health partnerships in response to high overdose deaths in the United States year after year. Here we provide best practice guidance for the structure and operations for post-overdose outreach programs as public-health responses to overdose.

Intended Audience

This document presents evidence-informed guidance to agencies that create, lead, manage, or fund post-overdose outreach programs in the United States.

The following guidance should be useful in the capacity-building and implementation phases of new and existing post-overdose outreach programs by: public health departments; community organizations; law enforcement, fire, and EMS agencies; and other organizations. This guidance document was informed by the experiences of a diverse group of organizations conducting post-overdose outreach and therefore considered the broad range of capacities, services, and activities that arise across different program configurations. Additional, more detailed implementation tools are needed to further support post-overdose outreach agencies. These tools include sample operating procedures and protocols and guidance on monitoring processes and outcomes.

While there are other interventions geared toward the post-overdose period, such as pre-hospital and emergency department-based interventions, they are beyond the scope of this document. This best practice guidance is focused on post-overdose programs that follow up in the community with overdose survivors in the days after an overdose.

Development Process

This best practice guidance was informed by the findings from a CDC-funded mixed methods evaluation study of post-overdose outreach programs in Massachusetts conducted between 2019 and 2022 known as the PRONTO Study, as well as a review of existing scientific literature. Massachusetts has reported over 2,000 opioid-related overdose deaths annually since 2016,[47] and was an early adopter of post-overdose outreach programs with almost half of the state's 351 municipalities implementing such programs between 2015 and 2019.[31]

The PRONTO study sought to characterize these post-overdose outreach programs, evaluate their effectiveness, and develop best practice guidance for their implementation. The specific aims of this study were to:

1) Complete a comprehensive inventory of Massachusetts programs using a statewide survey of local public safety and public health agencies;
2) Identify best practices, unintended consequences, and implementation barriers and facilitators using qualitative interviews with program staff, overdose survivors, and their social network;
3) Determine the effectiveness of programs in reducing opioid overdoses by comparing a) municipalities with and without programs and b) municipalities with and without selected key characteristics among programs, using interrupted time series analyses; and
4) Develop best practice guidance useful to public health and public safety agencies and other stakeholders based on findings from Aims 1-3 and a review of the literature, using a four-round modified Delphi process with a distinguished panel of experts.

This document is the product of the fourth study aim that convened a panel of 13 national policy and program experts to develop recommended guidance for post-overdose outreach programs, informed by current literature and new research findings. This panel reported an average of 22 years of experience in policy (n=7), public health (n=6), medicine (n=5), research (n=5), criminal justice (n=4), experience working on post overdose outreach interventions (n=3), the legal system (n=2), and lived experience (n=2) (note that each panelist was able to select multiple disciplines).

The multi-round modified Delphi process included four rounds of review by the expert panel. Importantly, the first two rounds were blinded among panelists, such that the identity of

individual panel members was not known to others on the panel. In Round 1, which was conducted individually via email in May of 2021, each panel member reviewed a summary of the findings from Aim 1-3 and a literature review on post-overdose outreach programs and then responded to a questionnaire about best practices in the following domains: initial comments; team composition; training; data access, collection, sharing, and privacy; initial visit procedures; information provided and referred to during outreach; involuntary civil commitment; program evaluation; program goals; law enforcement officer involvement; program funding; and overall comments. With each survey response they were asked to rate their confidence in responding. In Round 2, also conducted individually by email in June of 2021, responses to each survey question that met an 80% or greater confidence threshold were reviewed by the panel members, allowing comparison of the aggregate peer response to the individual's original response, with the opportunity to modify or update their answers. In Round 3, conducted via live video conference in two, 3-hour sessions in July and August 2021, the expert panel members were introduced to each other, and each domain was reviewed and discussed in order to confirm areas of consensus, discuss areas lacking consensus, and worked to clarify remaining discrepancies. Then, the study team reviewed, de-duplicated, consolidated, and standardized the proposed best practice guidance. For Round 4, in December 2021, the proposed best practice guidance and dissenting opinions were circulated by email for approval to all expert panel members. A draft guidance document was created based on these consensus best practices and circulated for comment, clarity, and approval to the expert panel, co-investigators, and selected community stakeholders in the Spring, Summer, and Fall of 2022.

Throughout the modified Delphi process, the expert panel consistently noted the importance of involving people with lived experience with substance use disorders and professional experience with post-overdose outreach in the development of the best practice guidance. This guidance represents the consensus of the expert panel. Guidance from individual members for which there was not consensus or that was raised outside of the Delphi panel process was not included in the document.

How to Use this Document

This document provides implementation guidance and recommendations for post-overdose outreach programs. Indeed, there is no one program design that will serve all communities. The guidance in this document is designed for consideration by local community stakeholders to make program design and implementation decisions that will best serve each unique community. Program sponsors might find this guidance useful in determining programmatic and evaluation criteria for funding.

Post-overdose outreach programs have emerged without a strong or clear evidence base at the outset. Therefore, program goals and operational strategies should be reviewed, reconsidered, and refined over the life of the program in order to achieve better public health outcomes and overdose prevention. This document is an initial effort at evidence-informed guidance and best practices for both new and existing programs.

The sections below outline guidance related to the following topics: (1) program goals; (2) program staffing; (3) training and supervision; (4) data collection, use, and sharing; (5) visit procedures; and (6) involuntary civil commitment. We have also enumerated areas for further development and research, as topics in this section have a limited evidence base and/or still lack consensus after the Delphi process.

Best Practice Guidance

Orientation

Overdose is a public health issue. Therefore, post-overdose outreach should be led and driven by public health principles.

1. Program Goals

Clearly stated goals are critical for post-overdose outreach programs to have impact and to evaluate effectiveness.

The primary goals for post-overdose outreach programs should be to:

- Prevent fatal overdose;
- Connect overdose survivors with harm reduction resources, evidence-based treatment for substance use disorder, and recovery supports; and
- Engage people at high risk for overdose who are not otherwise receiving services or practicing overdose prevention.

> **Note**: In order to optimize engagement, it is important to minimize criminal-legal consequences for the overdose survivor and/or others present at the post-overdose visit.

2. Program Staffing

This section provides guidance on outreach team staffing and on the recommended scope of involvement of three categories of outreach staff: Public health, community, or social service agency outreach staff; EMS/paramedic and firefighter staff; and law enforcement staff.

2.1 Recommendations for All Outreach Staff

1. Outreach staff should be familiar with the local community context and available resources in the community where the outreach is occurring and, ideally, be a member of that community.
2. Lived experience with substance use and overdose can be a strength in outreach staff and should be valued in staff hiring.
3. Outreach staff are subject to direct and secondary trauma and thus should receive training, support, and supervision that mitigate the negative effects of trauma exposure.
4. Outreach staff should appreciate and respect that there are multiple pathways to wellness, recovery, and other personal health goals for overdose survivors. To prevent overdose and promote health, evidence-based services (see Section 5.2.1) should be prioritized.
5. Programs should involve community members who are at risk of overdose (e.g., community advisory boards) to help determine the composition of post-overdose outreach teams, including which agencies and staff to include.

2.2 Public Health Staff

1. Individuals with training and experience in public health, community-based human services, or social work should staff post-overdose outreach programs. Well-suited professionals from these fields may include:
    - Community health workers

- Harm reduction outreach staff
- Public health department staff
- Recovery coaches
- Social workers

2. Public health staff should always be present on outreach visits and should be the primary point of contact with overdose survivors, including leading conversations on outreach visits.

2.3 Emergency Medical Services (Emergency Medical Technicians (EMTs)/ Paramedics) and Firefighters

1. EMS and firefighter partners should focus on providing support to the public health staff, to promote engagement of overdose survivors with community overdose prevention services.

2.4 Law Enforcement Personnel

1. Law enforcement-community relations should be considered when formalizing the role of law enforcement in post-overdose outreach. In communities where people who are at risk for overdose have strained relations with law enforcement, the involvement of law enforcement in the outreach efforts may be detrimental to engaging overdose survivors in harm reduction, treatment, and recovery services, and therefore should be limited.
2. Any law enforcement participation should focus on providing support to the public health staff, to promote survivor-directed engagement with community overdose prevention services that are free of coercion.
3. Programs with law enforcement staff should adopt procedures and practices that minimize actual or perceived coercion by law enforcement staff during post-overdose outreach. See examples of procedures and practices in Sections 3, 4.1, 4.2, and 5.4 that promote survivor-directed engagement with community overdose prevention services.
4. If a law enforcement agency employs non-sworn, clinically trained (e.g., nurse, social worker) or certified health professional (e.g., community health worker, recovery coach) staff, those staff should be prioritized as part of the outreach rather than sworn personnel.
5. If law enforcement staff are necessary to ensure staff and scene safety, those staff should be trained and experienced in behavioral health de-escalation and crisis response.

3. Training and Supervision

This section provides guidance about key training topics and core competencies for post-overdose outreach program staff.

1. Post-overdose outreach teams should receive initial and ongoing training (at least annually) that includes content on local harm reduction, evidence-based treatment, and recovery support service options in the community, including the availability and accessibility of those services for different segments of the population. Staff should be trained to refer overdose survivors to these services according to the individual's preferences, readiness, and needs.
2. The following table outlines specific training topics for all outreach staff.

Training Topics for All Post-Overdose Outreach Staff
• **Overdose identification, prevention, and response, including naloxone administration**
• **Introduction to substance use disorders and evidence-based, community accessible treatment, including medications for opioid use disorders and community resources**
• **Navigating the addiction treatment system**

- **Best practices for working with people who use drugs, including harm reduction approaches**
- **Harm reduction philosophy and strategies to engage and support people who use drugs**
- **Trauma-informed care, including de-escalation and crisis response[26]**
- **Implicit bias and stigma training with focus on disparities and equity**
- **Legal, regulatory, and ethical requirements for data safety and participant protection**
- **Preparing for the unexpected: staff, resources, and service response considerations. Topics should be locally defined and may include:**
  - **Grief supports for family when the person who has died, rather than survived**
  - **When family members are not aware of the overdose or the survivor's substance use**
  - **When the episode is not actually an overdose, but a medical event unrelated to substance use**
  - **Overdoses involved prescribed medications**
  - **Overdoses when children are present or that occur among children**
- **Outreach team member self-care**

3. Training should emphasize the right of outreach participants to accept or decline services and supports as they prefer and provide guidance on how to share information about available services during outreach in a way that is person-centered, survivor-directed, and trauma-informed.
4. Post-overdose outreach teams should be trained to educate overdose survivors about their rights to receive healthcare and social services free of discrimination. This includes freedom from discrimination by healthcare or other service providers as well as freedom from discrimination in the workplace (e.g., protections against workplace discrimination provided to people receiving medications for substance use disorders afforded by the Americans with Disabilities Act).
   - Staff conducting outreach should also receive the necessary training to refer survivors who feel they have been subject to discrimination to community resources.

4. Data Collection, Use, and Sharing

This section describes best practice guidance for collecting data both before and during outreach visits. It also includes guidance for data storage and sharing to protect the privacy of overdose survivors.

4.1 Data Collected to Identify Overdose Survivors

1. Post-overdose outreach programs should establish clear, written, and publicly available policies that describe conditions for the storage, use, and sharing of data received for the identification of overdose survivors, including any data that may be transferred from law enforcement agencies or other public safety partners.
2. Identifiable information about a possible overdose event or overdose survivor (e.g., data provided by a public safety agency) should be treated like protected health information and require safeguards to ensure confidentiality of data.
3. Programs should receive the minimum data necessary to identify and contact survivors. This may include name~~,~~ contact information, and details about the overdose event.

Note: Although law enforcement officers who provide data to outreach teams may also have access to information about warrants for the overdose survivor, this information should not be shared with the post-overdose outreach team. If warrant-checking reveals

substantive safety concerns, law enforcement should address those concerns before the outreach encounter and should occur separately from the outreach team's activities.

4.2 Data Collected During Outreach Contacts

1. No identifiable information should be recorded during the post-overdose outreach visit until explicit consent is provided by the overdose survivor.
2. Programs should establish clear, written, and publicly available policies that describe what information will and will not be collected during outreach visits as well as allowable conditions for the use or sharing of that information once explicit consent to do so is obtained from the overdose survivor.
3. Programs should record only the minimum data necessary to conduct outreach activities. This may include, name, contact information, or plans for follow-up.

Note: In order to protect overdose survivors' privacy and promote their engagement in prevention services, all information collected for and during outreach should be kept separate from any law enforcement investigations. This information should not be shared between or among law enforcement organizations, including probation or parole offices, drug courts, or other alternative court systems. Outreach teams should not share information gained during outreach visits with law enforcement agencies.

4.3 Data Shared to Conduct Outreach Activities

1. Programs should limit the sharing of identifiable information, such as the survivor's name, contact information, and information about the overdose event or substance use, to program staff and only transfer that information for the purpose of conducting outreach.
2. Programs may share identifiable information with other post-overdose outreach programs in different municipalities when all of the following conditions are met:
    - Multiple jurisdictions are implicated in the overdose emergency (e.g., if an overdose occurred in one municipality, but the survivor resides in another);
    - The survivor explicitly provides consent to share this information with other post-overdose outreach programs; and
    - Data are shared solely for the purpose of conducting outreach.

   This data sharing arrangement between agencies should be articulated in a memorandum of understanding that outlines data protections and is made publicly available.
3. When facilitating a referral for treatment or services, identifiable information should only be shared with entities outside of the post-overdose outreach program when the participant explicitly provides consent to the outreach team to provide this information to facilitate the referral.

4.4 Data Collected for Program Monitoring and Evaluation

1. Whenever possible, measurable outcomes related to program goals should be defined and subsequently monitored to assess program impact. When developing and implementing this evaluation plan, programs should:
    - Gather confidential feedback from staff, outreach recipients, family and friends of overdose survivors, and other community partners to improve service delivery;
    - Consider options for local oversight or an advisory group that may be helpful in review of ongoing operations; and
    - Publicly report aggregate level outcome measures and other program statistics.

5. Visit Procedures

This section includes guidance on outreach timing and methods, outreach activities including key services to provide or refer, approaches to protecting survivors' privacy during outreach visits, special considerations for law enforcement personnel conducting outreach visits, and involuntary civil commitment.

5.1 Outreach Timing and Methods

1. Initial outreach should be attempted within the 2-3 days following a non-fatal overdose.
2. When conducting in-person outreach, teams should consist of 2-3 staff members, each trained and experienced in community overdose prevention and outreach, as described in the above Program Staffing and Training sections.
3. Whenever possible, post-overdose outreach staff should attempt to contact an overdose survivor by phone or text to explain their purpose and obtain consent for further outreach before conducting an in-person visit.
4. When privacy, health, or safety considerations preclude an in-person visit to an overdose survivor's residence, phone-, video-, or text-based conversations can be alternative ways to provide overdose prevention and engagement support.
    - Subsequently mailing or dropping off materials in-person are reasonable alternatives to in-person visits that maintain privacy and confidentiality, provided the overdose survivor has given the post-overdose outreach team explicit consent to do so.
    - If a visit to an overdose survivor's home is not private, not preferred by the survivor, or not feasible for health and/or safety reasons, a meeting should be arranged with the overdose survivor at another location once initial contact is made and consent for an in-person visit is provided.
    - If privacy, health, or safety concerns are too great for an in-person visit to take place, delaying or foregoing the visit entirely may be necessary.

5.2 Outreach Activities

1. The following evidence-based services, supports, and referrals should be offered to overdose survivors and social network members who consent to receive them so the individual can make an informed choice about what is best for them:
    - Naloxone rescue kits and training on overdose prevention, identification, and response;
    - Harm reduction supplies that match an individual's substance use, including safer use supplies (e.g., sterile syringes, cookers, cottons, wound care kits, and personal syringe disposal units for people who inject; safer smoking equipment for people who smoke; snorting supplies for people who snort; condoms; fentanyl test strips; community drug checking services);
    - Linkage to local harm reduction service providers;
    - Linkage and initiation of evidence-based addiction treatment, including medications for opioid use disorder (e.g., methadone, buprenorphine, naltrexone);
    - Linkage to behavioral health and social service programs (e.g., housing, employment, transportation, legal, and education); and
    - Linkage to recovery support services (e.g., mutual help meetings, recovery support centers).
2. Programs should prioritize regular meetings and networking with local healthcare and service providers to establish effective relationships for referral.

3. Outreach staff should debrief with each other after each outreach visit, in order to enhance skills, competence, and confidence; reflect and support each other; and ensure that services continue to be performed in a way that is safe, ethical, and appropriate.

5.3 Protecting Privacy on Outreach Visits

1. To protect the privacy of overdose survivors, post-overdose outreach teams should disclose no information about the overdose survivor if someone other than (or in addition to) the survivor answers the door or the telephone.
    - When an explanation for the visit is necessary, the team should state they are doing "public health/community outreach."
    - The outreach team should only disclose information about the overdose survivor to family members, other caregivers, or friends, if they have already contacted and obtained explicit consent from the overdose survivor to do so.
    - The outreach team may provide services or referrals to family members if requested by the family member (e.g., naloxone rescue kits, family support resources).
2. To protect the privacy of overdose survivors, post-overdose outreach teams should not leave materials, such as naloxone rescue kits or fentanyl test strips, when no contact has been made with the overdose survivor at an attempted in-person visit.
    - If a post-overdose outreach program chooses to leave contact information, it should be limited and general, excluding any language about overdose or substance use. For example, business cards could list outreach staff as a "community outreach worker" rather than "overdose prevention specialist."

5.4 Considerations for Law Enforcement Personnel Present at Outreach Visit

1. If law enforcement staff are present during outreach, they should:
    - Arrive in the same, non-public safety vehicle as the rest of the team or, if arriving separately, in an unmarked law enforcement vehicle (marked law enforcement vehicles should not be used), in order to protect the privacy of survivors and families;
    - Wear an established post-overdose outreach team uniform, a "soft uniform," or plain clothes (standard law enforcement uniforms should not be worn);
    - Identify themselves as law enforcement officers to all individuals present and explain their role on the team at the time of team introduction; and
    - Avoid carrying firearms during post-overdose outreach visits to reduce the risk of escalating the encounter and of frightening or coercing overdose survivors. If departmental policies require sworn officers to carry a firearm while on duty, consider an exception for post-overdose outreach visits.
2. If law enforcement staff are present during outreach, programs should establish clear, written policies defining how infractions observed during the outreach visit (e.g., observing a small amount of drugs in an apartment for personal use) should be responded to. If law enforcement officers are required to report on or arrest for infractions, they should not be involved in post-overdose outreach visits.
3. If law enforcement staff are present at outreach visits, they should not act on an active warrant during the outreach visit. If law enforcement officers are required to act on a warrant, they should act on it outside of the outreach visit and not be involved in the post-overdose outreach visit.
    - Law enforcement staff conducting outreach should only discuss an active warrant if the overdose survivor requests information about their warrants or how to respond

to a warrant that is active. To prevent coercion—or the appearance of coercion—discussions about warrants should not be initiated by the outreach team, even as a strategy for engagement.
- Outreach teams should be prepared to provide written information about and contact information for legal counsel including assistance with warrants.

5.5 Involuntary Civil Commitment

Some states have laws establishing procedures for involuntary civil commitment or compulsory treatment to commit people who are using substances to inpatient treatment programs against their will when they are determined by a judge to be a danger to themselves or others. Depending on the state, commitments can be made at the request or petition of blood relatives, clinicians, court officials, or law enforcement. Because evaluations of the use of involuntary civil commitment have produced mixed results and some indicate that the use of involuntary civil commitment may cause additional harms,[48] the use of involuntary civil commitment in post-overdose outreach should be limited, if used at all.

1. To ensure that the outreach activities remain survivor-directed and minimize the risk of re-traumatizing overdose survivors or engendering mistrust, post-overdose outreach teams should not serve as a petitioner (i.e., directly file a written petition or affidavit) for the involuntary civil commitment of an overdose survivor.
2. Post-overdose outreach staff should be knowledgeable about the involuntary civil commitment laws and systems in their states, as provisions and practices vary by state.
3. Post-overdose outreach team members should discuss involuntary civil commitment only when an overdose survivor explicitly asks about or requests further information on this topic. To ensure that the outreach activities remain survivor-directed and minimize the risk of triggering trauma or mistrust, staff should avoid raising the topic of involuntary civil commitment with survivors or their family or friends.
4. When directly asked about involuntary civil commitment by a survivor, family, or friends, post-overdose outreach staff should provide standardized, descriptive information about involuntary civil commitment, including which agencies operate these programs (e.g., treatment provider or corrections institution), the procedures that result in the involuntary treatment, how people who are civilly committed are treated, and referrals to other community resources for additional information or assistance.

Strength of Evidence

This best practice guidance is based on expert panel opinion informed by a review of study findings and a literature review that consisted of descriptive and observational studies of programs. Evidence that tests the effectiveness of post-overdose outreach programs is either unavailable or does not permit a conclusion at this time and therefore the strength of evidence is rated as Insufficient.

Areas for Further Development and Research

Several topics identified by the expert panel suggest the need for further research and development. In some cases, the expert panel discussed the topic but were unable to come to consensus; in other cases, the group determined that more research rather than expert opinion was needed before further guidance could be extended.

1. A major gap in this document and the research base is an understanding of how to tailor post-overdose outreach programs for American Indian, Alaskan Native, Black, Hispanic and Latino, and other people (e.g., youth, gender minorities, and people involved in sex work) who have been both historically and presently disproportionately impacted by the criminalization of substances and thus are less likely to engage with post-overdose outreach. Research, program development, and evaluation are needed for these communities to provide programs that will help them reduce their overdose risk.[26]
2. Establishing a national public health-centered, evidence-focused training and technical assistance (TTA) resource that coordinates and complements with the Bureau of Justice Assistance's Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) can support further development, dissemination, and implementation of best practices for post-overdose outreach programs.[49] This TTA resource should build local capacity so that community public health entities can take on leadership of post-overdose outreach programs and support programs that were created, developed, and/or managed by law enforcement agencies to evolve into public-health centered programs.
3. Law enforcement practices and expectations are also evolving rapidly. This guidance document will benefit from future revisions that consider such practice change. For instance, the expert panel did not address the use of body cameras in post-overdose outreach visits.
4. Overdose survivors and their families face institutional stigmatization and criminalization, not only from law enforcement and the court systems, but also in the medical, addiction treatment, and social service systems. The expert panel did not focus directly on the bias within these systems. They warrant attention in the future to make them more accessible and effective for overdose survivors and their families.
5. Further research is needed to understand how best to fund these programs. Because they often involve community-based partnerships, the manner of funding likely has a substantial impact on the power dynamics within the partnerships that may have programmatic effects driven by the priorities of an individual funded partner, rather than the overall program goals.
6. While this guidance document focuses on the aftermath of an overdose event that has already been identified and responded to as an emergency by medical-legal entities, we acknowledge that there are many efforts underway to improve community capacity and re-examine law enforcement involvement in medical and mental health emergency event responses in the first place. These include, for instance:
    a. The federally created 988 Hotline for Mental Health Emergencies;[50,51]
    b. Never Use Alone, a national hotline that provides real-time over-the-phone monitoring and response for people who use drugs;[52] and
    c. Programs like CAHOOTS (Crisis Assistance Helping Out On The Streets) in Oregon, which employ unarmed mobile crisis intervention teams in emergencies involving homelessness, mental health, and addiction, and have successfully reduced the involvement of law enforcement in emergency response, including overdose response.[53]

    The rapidly emerging evidence and innovations in this area suggest the need for future expert review and guidance.
7. The COVID-19 pandemic has disproportionately impacted people living with SUD, who may be at greater risk for COVID-19 infection and face greater social and psychological consequences of the pandemic.[54–59] Additional research is needed to understand the effects

of the pandemic on these programs and evaluate any resulting program changes, as well as prepare for other major disruptions to care and services in the future.

8. Overdose deaths involving stimulants, including cocaine and methamphetamine, have been surging. Further research and program development are warranted to understand how post-overdose outreach programs can be adapted to engage and help people who use stimulants.

References

1. *Understanding Drug Overdoses and Deaths*. Centers for Disease Control and Prevention; 2021. Accessed October 17, 2022. https://www.cdc.gov/drugoverdose/epidemic/index.html

2. Gladden RM, O'Donnell J, Mattson CL, Seth P. Changes in Opioid-Involved Overdose Deaths by Opioid Type and Presence of Benzodiazepines, Cocaine, and Methamphetamine — 25 States, July–December 2017 to January–June 2018. *MMWR Morb Mortal Wkly Rep*. 2019;68(34):737-744. doi:10.15585/mmwr.mm6834a2

3. Ahmad F, Rossen L, Sutton P. Provisional Drug Overdose Death Counts. Published online 2022.

4. Khatri UG, Pizzicato LN, Viner K, et al. Racial/Ethnic Disparities in Unintentional Fatal and Nonfatal Emergency Medical Services–Attended Opioid Overdoses During the COVID-19 Pandemic in Philadelphia. *JAMA Netw Open*. 2021;4(1):e2034878. doi:10.1001/jamanetworkopen.2020.34878

5. Friedman J, Hansen H, Bluthenthal RN, Harawa N, Jordan A, Beletsky L. Growing racial/ethnic disparities in overdose mortality before and during the COVID-19 pandemic in California. *Prev Med*. 2021;153:106845. doi:10.1016/j.ypmed.2021.106845

6. Kariisa M, Davis NL, Kumar S, et al. *Vital Signs:* Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. *MMWR Morb Mortal Wkly Rep*. 2022;71(29):940-947. doi:10.15585/mmwr.mm7129e2

7. Han B, Einstein EB, Jones CM, Cotto J, Compton WM, Volkow ND. Racial and Ethnic Disparities in Drug Overdose Deaths in the US During the COVID-19 Pandemic. *JAMA Netw Open*. 2022;5(9):e2232314. doi:10.1001/jamanetworkopen.2022.32314

8. Friedman JR, Hansen H. Evaluation of Increases in Drug Overdose Mortality Rates in the US by Race and Ethnicity Before and During the COVID-19 Pandemic. *JAMA Psychiatry*. 2022;79(4):379. doi:10.1001/jamapsychiatry.2022.0004

9. Weiner SG, Baker O, Bernson D, Schuur JD. One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose. *Annals of Emergency Medicine*. 2020;75(1):13-17. doi:10.1016/j.annemergmed.2019.04.020

10. Larochelle MR, Bernstein R, Bernson D, et al. Touchpoints – Opportunities to predict and prevent opioid overdose: A cohort study. *Drug and Alcohol Dependence*. 2019;204:107537. doi:10.1016/j.drugalcdep.2019.06.039

11. Olfson M, Wall M, Wang S, Crystal S, Blanco C. Risks of fatal opioid overdose during the first year following nonfatal overdose. *Drug and Alcohol Dependence*. 2018;190:112-119. doi:10.1016/j.drugalcdep.2018.06.004

12. Caudarella A, Dong H, Milloy MJ, Kerr T, Wood E, Hayashi K. Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs. *Drug and Alcohol Dependence*. 2016;162:51-55. doi:10.1016/j.drugalcdep.2016.02.024

13. Stoové MA, Dietze PM, Jolley D. Overdose deaths following previous non-fatal heroin overdose: Record linkage of ambulance attendance and death registry data: Overdose mortality following heroin overdose. *Drug and Alcohol Review*. 2009;28(4):347-352. doi:10.1111/j.1465-3362.2009.00057.x

14. Bagley SM, Schoenberger SF, Waye KM, Walley AY. A scoping review of post opioid-overdose interventions. *Preventive Medicine*. 2019;128:105813. doi:10.1016/j.ypmed.2019.105813

15. Worthington N, Gilliam T, Mital S, Caslin S. First Responder Assertive Linkage Programs: A Scoping Review of Interventions to Improve Linkage to Care for People Who Use Drugs. *Journal of Public Health Management and Practice*. 2022;28(Supplement 6):S302-S310. doi:10.1097/PHH.0000000000001611

16. Champagne-Langabeer T, Bakos-Block C, Yatsco A, Langabeer JR. Emergency medical services targeting opioid user disorder: An exploration of current out-of-hospital post-overdose interventions. *J Am Coll Emerg Physicians Open*. 2020;1(6):1230-1239. doi:10.1002/emp2.12208

17. Yatsco AJ, Champagne-Langabeer T, Holder TF, Stotts AL, Langabeer JR. Developing interagency collaboration to address the opioid epidemic: A scoping review of joint criminal justice and healthcare initiatives. *International Journal of Drug Policy*. 2020;83:102849. doi:10.1016/j.drugpo.2020.102849

18. Langabeer J, Champagne-Langabeer T, Luber SD, et al. Outreach to people who survive opioid overdose: Linkage and retention in treatment. *Journal of Substance Abuse Treatment*. 2020;111:11-15. doi:10.1016/j.jsat.2019.12.008

19. Scott CK, Grella CE, Nicholson L, Dennis ML. Opioid recovery initiation: Pilot test of a peer outreach and modified Recovery Management Checkup intervention for out-of-treatment opioid users. *Journal of Substance Abuse Treatment*. 2018;86:30-35. doi:10.1016/j.jsat.2017.12.007

20. Formica SW, Reilly B, Duska M, et al. The Massachusetts Department of Public Health Post Overdose Support Team Initiative: A Public Health-Centered Co-Response Model for Post-Overdose Outreach. *J Public Health Manag Pract*. 2022;28(Suppl 6):S311-S319. doi:10.1097/PHH.0000000000001574

21. North Carolina Department of Public Health. *Post-Overdose Response Team (PORT) Toolkit*. North Carolina Department of Health and Human Services; 2020.

22. Donnelly EA, O'Connell DJ, Stenger M, Arnold J, Gavnik A. Law Enforcement-Based Outreach and Treatment Referral as a Response to Opioid Misuse: Assessing Reductions in Overdoses and Costs. *Police Quarterly*. Published online December 3, 2022:109861112211437. doi:10.1177/10986111221143784

23. Firesheets K, Juarez S, Kopak A, Ross J, Sperber K, Reichert J. Naloxone Plus, Plus Some: Examining Ohio's Quick Response Teams Through the Lens of Deflection. *Journal of Public Health Management and Practice*. 2022;28(Supplement 6):S330-S338. doi:10.1097/PHH.0000000000001570

24. Manchak SM, Gosney ME, Haberman C, Firesheets KC. A Data-Driven Response to the Addiction Crisis in Hamilton County, Ohio. *Journal of Public Health Management and Practice*. 2022;28(Supplement 6):S320-S325. doi:10.1097/PHH.0000000000001566

25. Formica SW, Waye KM, Benintendi AO, et al. Characteristics of post-overdose public health-public safety outreach in Massachusetts. *Drug and Alcohol Dependence*. 2021;219:108499. doi:10.1016/j.drugalcdep.2020.108499

26. National Council for Mental Wellbeing. *Training and Educating Public Safety to Prevent Overdose among Black, Indigenous and People of Color Communities: Environmental Scan*.; 2021.

27. High Intensity Drug Trafficking Areas. *The 2018 Overdose Response Strategy Cornerstone Project*.; 2018. Accessed October 17, 2022. https://www.hidtaprogram.org/pdf/cornerstone_2018.pdf

28. Formica SW, Apsler R, Wilkins L, Ruiz S, Reilly B, Walley AY. Post opioid overdose outreach by public health and public safety agencies: Exploration of emerging programs in Massachusetts. *International Journal of Drug Policy*. 2018;54:43-50. doi:10.1016/j.drugpo.2018.01.001

29. High Intensity Drug Trafficking Areas. *The Overdose Response Strategy: 2018 Annual Report*.; 2018. http://www.hidta.org/wp-content/uploads/2020/04/2018-ORS-Annual-Report.docx-00000003.pdf

30. Who covers law enforcement overdose response costs? Published online September 17, 2014. https://bjatta.bja.ojp.gov/naloxone/who-covers-law-enforcement-overdose-response-costs

31. Baker-Polito Administration Awards Funding for Home Visiting Program to Support Individuals and Families Coping with Opioid Addiction. Published online November 16, 2017. Accessed October 17, 2022. https://www.mass.gov/news/baker-polito-administration-awards-funding-for-home-visiting-program-to-support-individuals-and-families-coping-with-opioid-addiction

32. Flath N, Tobin K, King K, Lee A, Latkin C. Enduring Consequences From the War on Drugs: How Policing Practices Impact HIV Risk Among People Who Inject Drugs in Baltimore City. *Substance Use & Misuse*. 2017;52(8):1003-1010. doi:10.1080/10826084.2016.1268630

33. Footer KH, Silberzahn BE, Tormohlen KN, Sherman SG. Policing practices as a structural determinant for HIV among sex workers: a systematic review of empirical findings. *Journal of the International AIDS Society*. 2016;19:20883. doi:10.7448/IAS.19.4.20883

34. *The Growth of Incarceration in the United States: Exploring Causes and Consequences*. National Academies Press; 2014:18613. doi:10.17226/18613

35. Camplain R, Camplain C, Trotter RT, et al. Racial/Ethnic Differences in Drug- and Alcohol-Related Arrest Outcomes in a Southwest County From 2009 to 2018. *Am J Public Health*. 2020;110(S1):S85-S92. doi:10.2105/AJPH.2019.305409

36. Edwards F, Lee H, Esposito M. Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. *Proc Natl Acad Sci USA*. 2019;116(34):16793-16798. doi:10.1073/pnas.1821204116

37. Lett E, Asabor EN, Corbin T, Boatright D. Racial inequity in fatal US police shootings, 2015–2020. *J Epidemiol Community Health*. 2021;75(4):394-397. doi:10.1136/jech-2020-215097

38. Findling MG, Casey LS, Fryberg SA, et al. Discrimination in the United States: Experiences of Native Americans. *Health Serv Res*. 2019;54(S2):1431-1441. doi:10.1111/1475-6773.13224

39. Fatal police violence by race and state in the USA, 1980–2019: a network meta-regression. *The Lancet*. 2021;398(10307):1239-1255. doi:10.1016/S0140-6736(21)01609-3

40. Evans-Campbell T. Historical Trauma in American Indian/Native Alaska Communities: A Multilevel Framework for Exploring Impacts on Individuals, Families, and Communities. *J Interpers Violence*. 2008;23(3):316-338. doi:10.1177/0886260507312290

41. Nellis A. The color of justice: Racial and ethnic disparity in state prisons. Published online 2016. http://arks.princeton.edu/ark:/88435/dsp01bz60d032q

42. Daniel R. Since you asked: What data exists about Native American people in the criminal justice system? Published online 2020. https://www.jstor.org/stable/resrep27312#metadata_info_tab_contents

43. Weitzer R, Tuch SA. Race and Perceptions of Police Misconduct. *Social Problems*. 2004;51(3):305-325. doi:10.1525/sp.2004.51.3.305

44. Johnson D, Wilson DB, Maguire ER, Lowrey-Kinberg BV. Race and Perceptions of Police: Experimental Results on the Impact of Procedural (In)Justice. *Justice Quarterly*. 2017;34(7):1184-1212. doi:10.1080/07418825.2017.1343862

45. Gebbie K, Merrill J, Tilson HH. The Public Health Workforce. *Health Affairs*. 2002;21(6):57-67. doi:10.1377/hlthaff.21.6.57

46. Leveraging Data Sharing for Overdose Prevention Legal, Health, and Equity Considerations. Published online June 2020. https://www.changelabsolutions.org/sites/default/files/2020-07/LeveragingDataSharingforOverdosePrevention_accessible_FINAL_20200707.pdf

47. *Data Brief: Opioid-Related Overdose Deaths among Massachusetts Residents*.; 2019. https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-november-2019/download

48. Werb D, Kamarulzaman A, Meacham MC, et al. The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*. 2016;28:1-9. doi:10.1016/j.drugpo.2015.12.005

49. Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). Published online September 2020. https://bja.ojp.gov/program/cossap/overview

50. Chatterjee R. New Law Creates 988 Hotline For Mental Health Emergencies. Published online October 2020. https://www.npr.org/sections/health-shots/2020/10/19/925447354/new-law-creates-988-hotline-for-mental-health-emergencies

51. *National Suicide Hotline Designation Act of 2020*.; 2020.

52. Never Use Alone. https://neverusealone.com/

53. Moore Gerety R. An Alternative to Police that Police can Get Behind. Published online December 2020. https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/

54. Dubey MJ, Ghosh R, Chatterjee S, Biswas P, Chatterjee S, Dubey S. COVID-19 and addiction. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*. 2020;14(5):817-823. doi:10.1016/j.dsx.2020.06.008

55. Columb D, Hussain R, O'Gara C. Addiction psychiatry and COVID-19: impact on patients and service provision. *Ir j psychol Med*. 2020;37(3):164-168. doi:10.1017/ipm.2020.47

56. Melamed OC, Hauck TS, Buckley L, Selby P, Mulsant BH. COVID-19 and persons with substance use disorders: Inequities and mitigation strategies. *Substance Abuse*. 2020;41(3):286-291. doi:10.1080/08897077.2020.1784363

57. Glick SN, Prohaska SM, LaKosky PA, Juarez AM, Corcorran MA, Des Jarlais DC. The Impact of COVID-19 on Syringe Services Programs in the United States. *AIDS Behav*. 2020;24(9):2466-2468. doi:10.1007/s10461-020-02886-2

58. Wilkinson R, Hines L, Holland A, Mandal S, Phipps E. Rapid evidence review of harm reduction interventions and messaging for people who inject drugs during pandemic events: implications for the ongoing COVID-19 response. *Harm Reduct J*. 2020;17(1):95. doi:10.1186/s12954-020-00445-5

59. Ornell F, Moura HF, Scherer JN, Pechansky F, Kessler FHP, von Diemen L. The COVID-19 pandemic and its impact on substance use: Implications for prevention and treatment. *Psychiatry Research*. 2020;289:113096. doi:10.1016/j.psychres.2020.113096

Terms and Definitions

Alternate Help Seeking (988)

988 is a nationwide phone number in the United States for people to connect with suicide prevention and mental health crisis counselors. This phone number is accessible to everyone across the United States. It routes callers to the National Suicide Prevention Lifeline (1-800-273-TALK)[*].

Community Health Worker

A community health worker is someone who works within the local healthcare system and has a close relationship with the community they serve. Often, they will serve as a liaison between organizations/institutions and the community.

Emergency Medical Services (EMS)

EMS is an integrated, emergency health service system. A variety of different professionals with different qualifications work within the EMS system, including emergency medical technicians (EMTs), paramedics, and sometimes other health professionals including EMS-trained firefighters.

Harm Reduction and Harm Reduction Services

Harm reduction is an approach that aims to reduce the negative consequences of substance use while prioritizing the autonomy and dignity of people who use drugs. Harm reduction interventions and strategies that promote safer substance use and linkage to services include access to materials like sterile injection equipment, fentanyl test strips, and naloxone rescue kits to reverse opioid overdose. Harm reduction programs include syringe service programs, drug user health programs, safer drug consumption spaces which are also known as overdose prevention sites, or supervised injection facilities.

Harm Reductionist

A harm reductionist is someone who embraces a harm reduction approach to minimizing the negative consequences of substance use. During post-overdose outreach visits, a harm reductionist may provide education on safer substance use practices, including safer injection.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 protects how personally identifiable information is maintained and disclosed by covered entities like healthcare providers. EMTs and the emergency response agencies that employ them are considered covered entities, whereas police departments who are not engaged in the provision of healthcare services are not. Fire departments are not covered entities unless they provide emergency medical services.

Involuntary Civil Commitment

This term refers to any process of court-mandated or otherwise involuntary inpatient treatment for substance use disorders. Statutes regarding involuntary civil commitment vary from state to state. Where such procedures exist, individuals qualified by state law (generally a blood relative, spouse, police officer, court official, physician, or guardian) may request a judge's order to involuntarily commit another person when there is reason to believe that person poses a threat of serious harm to self or others as a result of their substance use.

---

[*] Federal Communications Commission. Suicide Prevention Hotline. Accessed November 8, 2022. https://www.fcc.gov/suicide-prevention-hotline

Law Enforcement

This term is used to refer to any and all agencies and individuals involved in law enforcement, including but not limited to police officers, sheriffs and sheriff's deputies, state troopers, federal agencies such as the FBI or DEA, fire marshals, and probation and parole officers.

Linkage

A facilitated referral, consistent with a warm hand off, when the outreach team makes an appointment and/or otherwise notifies a service provider that the overdose survivor may be coming for services. Linkage may include making an introduction between the overdose survivor and the service agency.

Naloxone

Naloxone, commonly known by the brand name NARCAN®, is a prescription medication that quickly reverses the respiratory depression that can cause an opioid overdose. Naloxone is an opioid antagonist, meaning it blocks opioids from binding to opioid receptors. Many public safety personnel, layperson bystanders, and people who use drugs receive training in how to identify and respond to an opioid overdose using naloxone.

Naloxone Rescue Kit

Naloxone, also known as NARCAN®, is available in several different formulations for administration nasally, intramuscularly, or subcutaneously. A naloxone rescue kit includes the medicine, instructions for use, and either syringes and needles, a nasal spray device, or an auto-injector.

Person-Centered Approach

Person-centered outreach is an approach in which the survivor is empowered as a partner in outreach rather than as a recipient. This acknowledges that outreach should not be a passive communication of information.

Post-Overdose Outreach

Post-overdose outreach programs engage overdose survivors and/or their social networks (family, friends) in the days following an overdose. Though programs vary, they typically obtain contact information from emergency service calls (i.e., 911 calls) and conduct outreach visits at the survivor's residence to provide education and referrals to harm reduction services, substance use treatment, and other social services.

Protected Health Information (PHI)

Protected health information describes all individually identifiable health information that is protected by the HIPAA Privacy Rule, such as medical history, test results, and location, as defined in the Code of Federal Regulations.

Public Health Organizations and Personnel

This is a broad term to describe public health, community, and social service agency staff members. This includes, but is not limited to recovery coaches, harm reductionists, community health workers, and social workers.

Recovery Coach

Recovery coaches are trained and, in some states, certified professionals with lived experience of substance use disorder who provide social support and treatment navigation services to people experiencing substance use disorders.

Recovery Support Services

Recovery support services include mutual support, such as 12-step programs, housing, family, education, employment, transportation, and nutrition services tailored for people seeking remission from substance use disorder. Recovery support acknowledges that there

are multiple pathways to recovery and that an individual's choice should be central and respected.

Survivor-Directed Approach

Survivor-directed outreach centers the experiences and input of overdose survivors. This input is used in the planning and practices of post-overdose outreach.

Trauma-Informed Approach

Trauma-informed outreach understands that trauma can have emotional, social, and physical impacts on an individual. This approach addresses trauma and avoids re-traumatization by recognizing the impact of trauma.