Position Paper on Community Strategies for Post-Opioid Overdose Interventions

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Contents

Introduction

Across the United States (US), opioid overdose fatality is a major public health emergency. The number of fatal opioid overdoses has steadily increased over the past 20 years, swelling to over 67,000 identified opioid-related fatalities in 2018[1].

In New York State (NYS), communities are struggling with how best to respond to problematic drug use, inconsistent or inaccessible support services, and the persistent occurrence of opioid overdose incidents. Fatal opioid overdoses occurred in NYS at a rate of 16.1 deaths per 100,000 persons, compared with the national average of 14.6[2] and has increased every year since 2011. Naloxone (brand name Narcan) is used to treat an individual experiencing an opioid overdose emergency and is now widely available to NYS residents through pharmacy access, community-based training and distribution, and social events. However due to stigma, economics, and location, naloxone may be harder to access for some individuals.

To respond to this significant public health emergency, there is growing interest in post-opioid overdose outreach interventions as a public health strategy. Pioneered by people who use drugs (PWUD) and harm reduction (HR) organizations, the practice of providing follow-up care and support to an individual who has experienced an opioid overdose incident is a common-sense approach to supporting the health and wellness of PWUD. Post-opioid overdose outreach interventions have recently gained popularity among public health and public safety entities. Across the State, outreach teams have successfully partnered with law enforcement to access contact information for opioid overdose survivors for the purpose of conducting post-overdose outreach visits. These visits offer the opportunity to direct people to HR services including medication for opioid use disorder (MOUD) and the provision of naloxone, training, and overdose prevention materials; ultimately providing stakeholders an opportunity to work together to reduce overdose mortality.

> "A lot of times when talking with people… you can tell it's the first time someone's been kind to them in a very long time. Folks don't get a lot of kindness that are using substances."
>
> -Chase Holleman, Guilford County Solution to the Opioid Problem

Post-opioid overdose outreach interventions are becoming increasingly common as a public health tool designed to reduce overdose fatalities and facilitate healthcare and social service utilization for PWUD. This guide will provide an overview of what post-opioid overdose outreach interventions are and will outline suggestions on how to develop strategies to support PWUD, their loved ones, and their communities. This guide is meant to invite the reader to think critically about what type of team composition, philosophical approaches, and services will have the greatest success of meeting the shared goal of reducing fatal opioid overdose.

This document reviews the creation of an outreach team, sharing of information, legal issues for PWUD, how to conduct a post-overdose visit, and evaluation of the intervention.

Limitations of this Document

Although post-opioid overdose outreach strategies have been utilized by HR providers for decades, the practice as a formal intervention is newly emerging. Researchers and public health agencies have only recently begun to develop the outcome and evaluation measures necessary to determine efficacy. To date, there are no best practices documents or peer-reviewed literature on whether post-opioid overdose interventions change behavior, decrease risk or reduce opioid overdose mortality. There is also no research to determine if a specific strategy may increase harm.

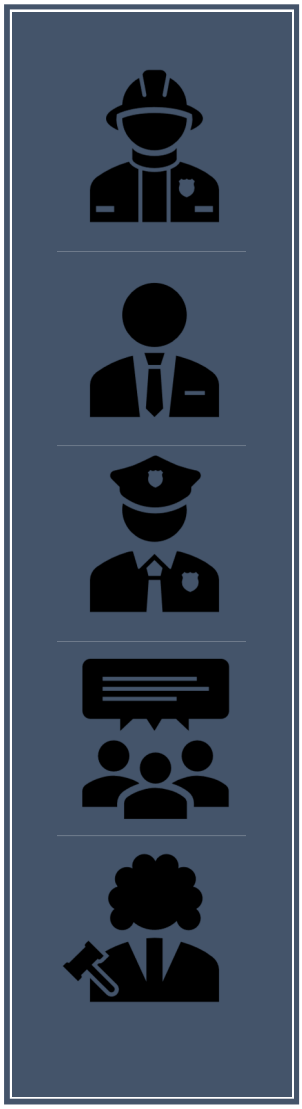
Despite these limitations, this guidance builds off evidence on the efficacy of community-based, particularly peer-based, HR interventions to engage and support the health and wellness of PWUD[3,4,5]. Emerging research has found that HR interventions are sound public health practices and are successful at preventing opioid overdose fatality and removing barriers to care for PWUD[6,7,8,9,10]. Throughout the development process, the question "Are we doing any harm to overdose survivors and PWUD?" must be at the forefront of all decision making.

Developing a Post-Opioid Overdose Intervention

The aim of post-opioid overdose engagement (POE) is to engage individuals who have experienced a non-fatal overdose and offer them resources to support their safety, health, and ability to thrive. POEs target individuals who have experienced a non-fatal opioid overdose because overdose survivors have an elevated vulnerability to future overdose incidents[11,12]. The partner, family, and roommates of an opioid overdose survivor are critical players in preventing a future opioid overdose death[13,14]. Therefore, a secondary aim of POE is to provide resources such as overdose prevention training and naloxone to the overdose survivor's support system.

Creation of an Outreach Team

The development of successful POE requires effective partnerships across multiple stakeholder groups. POE structure, outcomes measures, evaluation, and code of conduct require a mindful planning process which can support institutional collaboration for the purpose of reducing opioid overdose fatality. With an eye toward pragmatic and positive interventions, bringing the right stakeholders to the table is crucial. The best candidates involved in these cross-sector coalitions are those who are champions for innovative approaches to drug user health, able to be flexible and work as a member of a team, and are enthusiastic about working with other stakeholders who may have differing opinions about the best course of action to reducing opioid overdose fatality.



Members of the Guidance Team

Below are recommended groups for inclusion in the development and evaluation process.

- Drug Treatment Programs and Certified Recovery Peer Advocates. Drug treatment programs are an important partner as they can provide a streamlined referral process for overdose survivors contacted through POE. Many drug treatment programs employ Certified Recovery Peer Advocates (CRPA) who are licensed by the Office of Addiction Services and Supports (OASAS). CRPAs are non-clinical professionals focused on supporting recovery from addiction, recovery education and coaching, MOUD, and guidance in how to use their lived experience to support individuals who actively use drugs. The role that CRPAs play depends on the agency in which they're employed; however, their general scope of service is built around removing barriers to recovery. CRPAs will provide insight around barriers and opportunities for POE teams. Also available are Centers of Treatment Innovation (COTI), which are certified providers focused on engaging people in treatment through mobile

clinic services. The COTIs bring treatment staff into unserved/underserved areas and offer enhanced peer outreach and engagement within the community.

- Local Governmental Departments. Local governmental departments can provide assistance in building relationships among the various stakeholders in the community. As the local government, these agencies have a unique position in bridging community-based providers and local law enforcement entities. Local Health Departments (LHDs) can develop data sharing agreements between such entities, support micro- and macro-level evaluation, and develop strategies including overseeing the coordination of rapid response plans. Local Offices of Community Service or Offices of Mental Health may also be involved in the overdose response and should be considered for inclusion.
- Law Enforcement Agencies. Recent studies have found that law enforcement wants to be engaged in solutions to opioid overdose mortality, and that as a profession, they are increasingly viewing the matter as a public health problem as opposed to a law enforcement problem[15]. Law enforcement can potentially report overdose survivor information to the POE team, report when overdose clusters are occurring, and collaborate on spike alert information using such tools as the Overdose Detection Mapping Application Program (ODMAP). When law enforcement officials have direct interaction with someone who has overdosed, they can discuss treatment and recovery options, and provide referral information to the individual. It is essential that law enforcement deprioritize carceral interventions, and instead prioritize redirecting (PWUD) toward appropriate options for care whenever possible.

> The adoption of ODMAP - a HIDTA (High Intensity Drug Trafficking Areas) developed overdose incident reporting system - has catalyzed an increase in public safety involvement in post-opioid overdose interventions. HIDTA leadership have made efforts to broaden the tool's mission beyond identifying drug trafficking patterns to include public health functionality. This has highlighted the necessity to better understand the design, evaluation, and effectiveness of post-opioid overdose outreach visits.

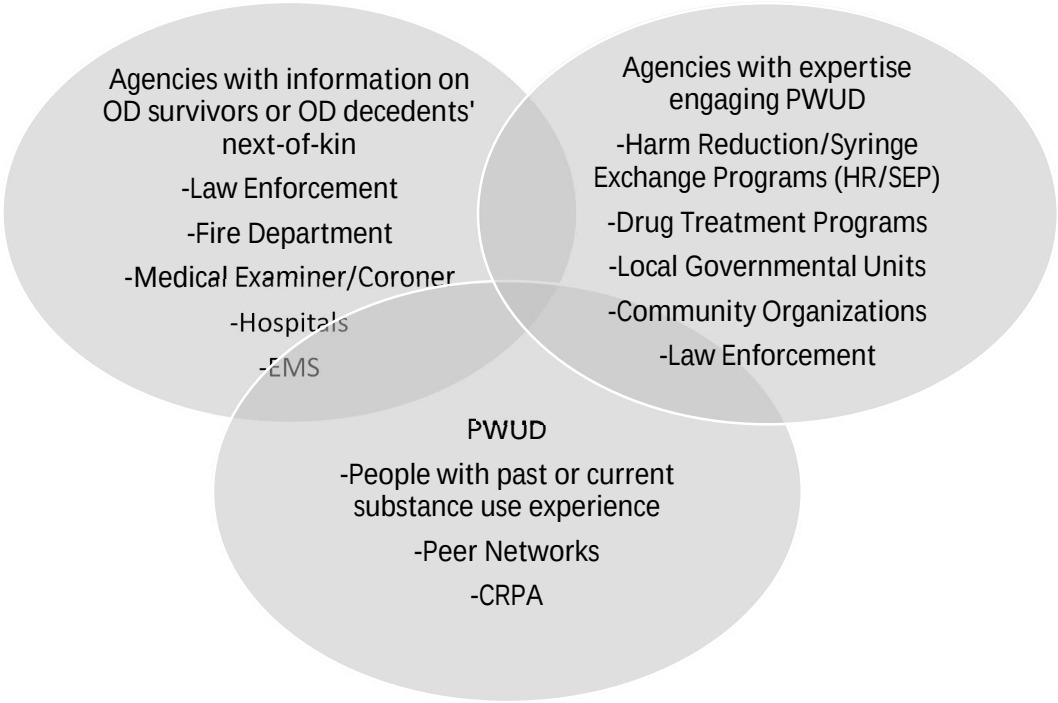
- Community-based Organizations (CBOs), Community Groups, and Faith-based Leaders. CBOs and community groups can support information sharing to individuals in recovery and their families and assist with outreach to individuals at high risk within their own service communities. These groups can also identify POE champions, appropriate treatment resources available, assess capacity and gaps in services, and facilitate a streamlined referral process. Faith-based leaders can play a crucial role by providing anti-stigma information, encouraging acceptance for PWUD, and supporting HR and evidence-based interventions such as MOUD. Faith-based leaders can also provide valuable emotional and spiritual support to the families of opioid overdose survivors.
- PWUD. PWUD, especially those who have experienced an opioid overdose, are a unique stakeholder. Choosing people with lived experience who can act as advocates helps to balance power dynamics. Meaningful involvement of PWUD in the design and evaluation of post-overdose interventions can determine if the intervention will meet the needs of overdose survivors.

- HR Programs. HR programs have been core support systems for PWUD in many communities across the state. All HR programs include peer programs and are particularly adept at engaging with PWUD. HR programs provide syringe exchange, overdose prevention, HIV/HCV testing, care management, counseling, Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), medication adherence, drug user health education, disease prevention education, and referrals to medical and social and treatment services including for MOUD. These programs are also an excellent source of training around evidence-based practice and cultural competency, along with opening dialogue around stigma and stigmatizing language (please see section on Training on page 8).
- Local Drug User Health Hub (DUHH). DUHH are specifically designed to provide support and guidance to people at risk of an opioid overdose. These centers work to improve access and linkages to health, MH and drug treatment services, and are social service leaders for PWUD. They are a referral source for law enforcement, treatment agencies, families and medical centers. DUHH are managed through existing HR programs and are located in Long Island, Albany, Buffalo, Ithaca, Syracuse, Plattsburgh, Newburgh, Rochester, Staten Island, Brooklyn, Manhattan, and the Bronx. These Health Hubs are overseen by the New York State Department of Health AIDS Institute's (NYSDOH AI) Office of Drug User Health (ODUH).

> "Non-fatal overdose is a really important opportunity to think about inserting prevention strategies that we know work. We want to provide connection to people… those services must be reliable, believable, trustworthy, and actually offer the person that uses drugs something that they want. People have to opt-in to want this ongoing connection with someone post-overdose - things like needle exchanges, naloxone access programs, other services like housing or insurance. In that way, when we build a relationship that's ongoing with people, then we are ready and poised to be supporting folks in accessing treatment when they're ready on their own timeline."
>
> -Maya Doe-Simpkins, Public Health Expert

Structure of a Post-Opioid Overdose Outreach Team

The structure of a post-opioid overdose outreach team will vary depending on resources, local infrastructure, the guidance team members, and belief systems about appropriate strategies for effective risk reduction. These teams are based in the community and each community should identify their appropriate team members. Teams can be multidisciplinary, HR or law enforcement, as described below. Local governmental units, including LHDs, offices of MH and crisis intervention teams may also be included on these teams. Teams can receive information from law enforcement, EMS, coroners, and others about the location of an overdose occurrence and contact details for the opioid overdose survivor.



Multidisciplinary teams generally consist of one or more public health worker and a law enforcement officer or other public safety representative. The core of the team should involve a HR/peer support/case management professional. Whenever possible, members of the community affected by opioid overdose should be individuals involved in the provision of resources and support. Law enforcement participation can have a dual function – both to forge partnerships with the PWUD community, and to assess the safety of the location and provide protection to the public health workers. Law enforcement officers on multidisciplinary teams can arrive and remain in a marked vehicle and are uniformed. Sometimes, the law enforcement officer approaches a residence and is the one to first knock on the door, introduce themselves, and communicate the intent of the visit. On other teams, the officer takes a less active role and does not exit the vehicle. Some teams have an EMS representative.

A HR team which could include street outreach workers, people with lived experience of drug use, PWUD, and social workers. While law enforcement is part of most multidisciplinary teams, HR teams do not have direct engagement from law enforcement officers[16]. This is largely due to the mistrust and stigmatized relationship between PWUD and law enforcement based upon previous experiences. HR programming is built around knowledge of drug user health resources and effective system navigation, information that is communicated to the overdose survivor.

In some rural areas, law enforcement are the most realistically available personnel for these interventions. Law enforcement are often familiar with and integrated into the community. If this is the case, it is in the best interest of the work to select a primary officer who wants to be meaningfully involved in POE and who has cultural competency, implicit bias and anti-stigma training. Law enforcement officials can work with the State Department of Health, closest syringe exchange program or Drug User Health Hub to receive training in harm reduction, as well as assess the availability of a harm reduction peer worker within their county. A referral relationship with a medical clinic, buprenorphine provider, and

mental health counselor who can provide same-day care is also advantageous. Transitioning overdose survivor care coordination to a harm reduction program, drug treatment provider, or Drug User Health Hub is preferred.

Legal Issues for Opioid Overdose Survivors

When law enforcement agencies are involved with a situation that includes illegal activities such as illicit drugs, there remains significant tension between the goals of law enforcement and public health. Good Samaritan laws have been developed to focus carceral attention away from PWUD calling 911 during drug overdose emergencies; however, the reality is that these substances are illegal in the United States, and possession of them puts people at risk of incarceration. Drug-induced homicide laws have been enacted in 25 states, instituting prison time for the person who sold a fatal overdose, who may be a friend or family member[17]. Police intervention and arrest can cause significant and secondary harms to PWUD and their community, as well as for communities of color [18]. Increased overdose mortality is often a result of a fear of police and arrest which results in delayed calls to 911[19]. Anecdotal reports indicate that police have been known to revisit the scene of a 911 call to make arrests a few days after the 911 call.

Currently, most non-Emergency Room POE originate with law enforcement involved opioid overdose incidents. The names and addresses of the people involved as well as the details of those law enforcement involved incidents are not considered protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This means that law enforcement can provide overdose survivor information to outside entities including state and local government as well as community groups for the purpose of advancing public health. Under HIPAA regulations, health care providers are unable to share survivor information. It is recommended that law enforcement's role in POE be limited to one-way data sharing when feasible, but it is recognized that public safety plays a major role in responding to calls for assistance during an overdose.

If utilized through a strategic process with appropriate stakeholder involvement, there is the ability to provide a critical connection between PWUD and health and social service opportunities. Receiving opioid overdose survivor information from law enforcement is a way for POE teams to incorporate a small amount of data into an actionable format. Furthermore, law enforcement's recognition that public health strategies are a necessary component of addressing opioid overdose mortality presents a positive starting point for inter-agency collaboration and reducing unnecessary criminal justice system involvement.

Collaboration Tools

A formal Data Use Agreement or Memorandum of Understanding that ensures mutual understanding of how sensitive information is shared between participating entities such as a law enforcement agency and a HR program (or other entity receiving the data) is necessary before starting the program.

Training for the Team

Training requirements should comprehensively prepare all POE team members for their roles. First responders may experience compassion fatigue associated with being on the frontlines of the opioid overdose epidemic. They may not possess the skillset to support drug using community members in moving through positive incremental change. Offering an array of appropriate trainings, such as those

listed below, can provide the team the tools they need to approach opioid overdose incidents with increased nuance and flexibility.

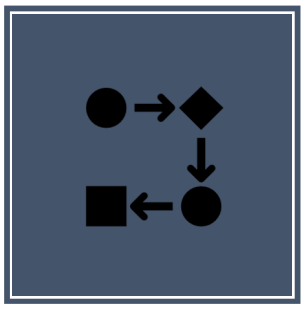
In addition to didactic methods, a variety of role-playing scenarios conducted by a knowledgeable trainer or supervisor can support the POE team members in laying the groundwork necessary to deliver competent and skillful services and be prepared when unexpected situations arise. Topics for trainings include but are not limited to opioid overdose prevention (OOP) and response, naloxone administration, HR philosophy, cultural competence, anti-racism, stages of change, motivational interviewing, crisis intervention and conflict de-escalation. Because an overdose incident can occur at the POE location, each POE team member should be trained in opioid overdose response and carry naloxone.

Supervision sessions for POE team members can enhance skills and competencies as well as prevent burn-out among staff. Individual supervision is a space for a POE team member to explore feelings of hopelessness, fatigue or anxiety related to their experience in the field. Screening for suicide risk and providing coping strategies is important for team members as well as clients. QPR, which stands for Question, Persuade and Refer, are 3 simple steps that can be taken to help prevent suicide. Managers or supervisors may consider becoming trained in QPR, and offering the training to staff. People trained in QPR learn how to recognize the warning signs of a suicide crisis, how to offer hope, and get the person the help they need[20]. It's important to note that team members may not know if an overdose was intentional or unintentional, so being aware of the potential for self-harm/suicidal behavior is critical.

Group supervision can touch on the successes or challenges of POE, review program evaluation metrics and participant feedback, and provide an opportunity for ongoing skill development.

Creation of the Intervention

Although POE strategies vary widely, there are several common denominators and similar operational aspects of many POE programs:



- The initial goal of a POE team is to build trust. POE teams first identify themselves to the opioid overdose survivor and communicate their purpose.
- Overdose prevention training and naloxone distribution is provided to the opioid overdose survivor and any other individuals who may be available to respond or at the scene of a future adverse event, to prevent a future opioid overdose fatality.
- Following the HR model, POE interventions focus on the goals of the opioid overdose survivor. Goals are not predetermined by the POE team.
- The services and referrals available through the POE team are communicated in a friendly, non-judgmental tone.
- Contact information for the POE team is provided to the opioid overdose survivor and their support system.
- A next step is discussed. This may be a follow-up phone call, visit or escort. Permission to engage in follow-up contact and activities is generally solicited.

Steps Involved in Intervention Visits

1. Engage an Individual

There are various options for when to engage an Individual with a POE team. The following are various examples of the engagement process:

- Overdose survivors opt-in to involvement with POE at the location of the incident through a consent form presented by first responders in paper or electronic format. First responders leave a card or pamphlet with the individual about the program including contact information for the POE team and details about the program, and information for the National Suicide Prevention Lifeline and Crisis Text Line (see graphics below). If the overdose survivor agreed on the consent form to be contacted for follow-up, contact information is shared with the POE team. The POE team then calls the individual or mails a letter informing them that they will be making a POE within a specific timeframe. This conversation or correspondence includes opt-out information in the event the individual changes his/her/their mind.
- Overdose survivors can be called using contact information provided by law enforcement (as mentioned above). The individual will be apprised of the POE resources available and a follow-up visit offered. Verbal consent should be obtained at the beginning of the conversation and a written consent collected at any in-person intervention.
- First responders leave a card or pamphlet with the individual at the location of an overdose. This will include an explanation of POE resources and contact information. It will then be up to the individual to reach out to the POE team.

The initial communication to an opioid overdose survivor should include but is not limited to:

- the mission of the POE team and purpose of intervention activities;
- introduction of team members;
- services that recipients can expect at various stages of the intervention; and
- an explanation of protocols in place to protect privacy.

2. Consent

Communication with opioid overdose survivors around consent is the first step in building a trusting, non-coercive relationships. Approaches to consent before and during POE interventions vary across program design but always emphasize that the overdose survivor or their loved ones may opt-out of services, referrals, or further contact with the team at any time.

During the initial POE, there should be a discussion about who the POE team can communicate with and under what circumstances. A disclosure consent form for the overdose survivor is also a helpful tool for many POE teams. Parties external to the POE team, including friends, family and other service providers, may want to access information from the POE team about the overdose survivor's treatment plan or referral outcome. The POE's first responsibility is to the overdose survivor; information-sharing will only take places with those parties the survivor has agreed to, either in writing or verbally.

3. Services

The following are services often provided during a POE. Each POE team must take their own infrastructure and resources into account when developing their service menu. The QPR process should always be employed. This will help the team member recognize the warning signs of suicide and know how best to proceed.

- Provide an assessment to explore if the overdose survivor has concerns and goals regarding their physical, mental, emotional, financial, familial, and legal situation. Develop a service plan with the individual.
- Provide emotional and psychosocial support not only to the person who has overdosed, but also to their friends, family, roommates, or other members of their immediate community.
- Distribute naloxone and provide overdose prevention education and response training. The POE team should provide naloxone for the survivor and others in their network.
- Develop an overdose response plan for future incidents.
- Provide syringes and hazardous waste disposal for people who inject drugs (PWID). Providing syringes may also facilitate connections between the POE team and other PWUD who are at risk

> "Not all well-intentioned approaches to addressing the opioid epidemic are good ideas. Some are based on evidence and experience, others on misunderstanding, blame, fear, or frustration."
>
> -Joshua Sharfstein, Vice Dean, John Hopkins Bloomberg School of Public Health

of opioid overdose. If it's not feasible to provide syringes, the POE team makes a referral to the local syringe access program (SAP) or explains pharmacy access.

- Refer to services including low-threshold buprenorphine and other MOUD; HIV/HCV testing, primary preventative care, and OB/GYN care; counseling, mental health or psychiatric services; domestic violence services; Veterans Administration; and benefits/entitlement enrollment including Medicaid, food stamps, and housing. Using QPR, the POE makes referrals accordingly.
- Assist in obtaining health insurance including mobile enrollment.
- Assist with transportation including taking individuals to appointments or accompanying them on a walk to a store for personal items.

If an opioid overdose survivor refuses services or support, the POE team can ask that they be allowed to check in with the individual in two to four weeks. Regardless, it is important for the POE team to leave information about POE services including contact information. Materials that are provided should underscore areas that may be of concern to a PWUD, including information about privacy and consent, the philosophical underpinnings of the work (HR), and that services are provided at no cost. Information about social services options, syringe exchange, drug treatment, and where to obtain overdose prevention training and naloxone should also be included. Many people prefer to manage their own care; the pamphlet should provide a gateway to services for an individual who does not want their care facilitated by a POE team.

4. Social Support

Although POE strategies primarily target the overdose survivor, it is important to address the emotional and practical needs of individual's support system as well. Providing support for family members and loved ones of an overdose survivor can be challenging and may require additional training and supervision. Some examples include:

- OOP and response training including naloxone distribution with family members, roommates, and friends. Encourage training in QPR if appropriate.
- Education about the process of substance use disorder and recovery including self-care for caregivers and considerations related to stigma and language use. This includes an ability to move between different theories and belief systems about substance use disorder and recovery.
- Provide active listening in a non-judgmental and empathic manner.
- Provide information about accessible wellness opportunities such as support groups and mental health care.

Although most individuals who live at the scene of an overdose are aware of the incident, it is important to consider the overdose survivor's privacy when approaching and/or communicating with their support system. The POE team needs to respect the autonomy of the survivor and support appropriate decision making when issues of privacy and consent arise.

Safety Issues for the Team

Safety plans are important in every occupation. Outlined below are some basic suggestions for developing a POE safety plan.

- All POE personnel are trained in crisis intervention and conflict de-escalation. POE teams usually perform outreach in pairs, but this is not a hard and fast rule. POE team members should ensure their phones are charged and that important contacts are in 'favorites' for easy access.
- Although all POE team members are trained in conflict de-escalation techniques, there may be some situations in which an interaction feels unsafe. Team members should use a predetermined safety phrase to communicate to one another if the location or situation feels unsafe and a POE team member wants to leave the location. Examples can include "My shirt is itchy, I used the wrong detergent again" or "This TV (book, couch) is the same one I have." The purpose of a safety phrase is to communicate necessary information such as 'I am feeling unsafe. We need to leave' through an innocuous but defined communication process.
- It is also recommended that POE team members discuss their own comfort level with a wide range of possible situations as well as triggers they might have in advance of providing POE interventions. It should be noted that PWUD are in general no more of a threat than other community members.
- It is recommended that the first visit occur in a public location, such as a coffee shop or park.

Evaluation

Although researchers are in the process of evaluating post-opioid overdose interventions[21], there are currently no best practices for evaluation of this intervention. Despite this, it is important for all POE activities to include evaluation measures as part of their overall program design.

The effectiveness of any intervention is evaluated using quantitative measures of success such as reduced opioid overdose mortality, referrals to drug treatment, and engagements with a community provider. We encourage POE teams to expand their evaluation measures to incorporate improvements in quality of life measures including housing and family stability, reduction in criminal justice involvement, and qualitative feedback related to non-treatment indicators such as overdose knowledge, self-efficacy, and satisfaction with the program.

Feedback from communities targeted by the intervention - whether they have been successfully contacted or not - provides essential data about how interventions, strategies, and outreach materials can be improved. Gathering regular feedback from overdose survivors may be one of the most powerful methods that stakeholder groups can use to meaningfully improve strategies. Some suggestions for how to do this include:

- Make feedback anonymous to improve the integrity of data.
- Solicit meaningful feedback by including all individuals and households targeted, not only those that have been successfully contacted. This may mean developing a mail-based, telephone, or online survey. It is best to include an incentive for participation.
- Request demographic information, when appropriate, from participants and observe how feedback may vary by race, gender, sexual orientation, and class.

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