NATIONAL ASSOCIATION of COUNTIES NACo

OPIOID SOLUTIONS CENTER

OPIOID SOLUTIONS STRATEGY BRIEFS

Eight high-impact eligible expenditures of opioid settlement funds

ABOUT NACo's OPIOID SOLUTIONS CENTER

NACo's Opioid Solutions Center empowers local leaders to invest resources in effective treatment, recovery, prevention and harm reduction practices that save lives and address the underlying causes of substance use disorder. The Opioid Solutions Center features:

- Planning tools: Custom tools for administering funds from the national opioid settlements.
- Decision making tools: Briefs on high impact opioid abatement strategies that are approved uses of opioid settlement funds.
- Peer learning opportunities: In-person and virtual peer learning programs for county opioid settlement decision makers.

To learn more, visit www.naco.org/opioid.

ABOUT THE STRATEGY BRIEFS

Funding from the national opioid settlements presents an opportunity for counties to sustain and strengthen our response to the ongoing opioid epidemic. The settlement agreements require that the majority of funds be invested in future opioid abatement and provide an extensive, though not exhaustive, list of eligible expenditures.

To help counties assess and prioritize the many approved uses of opioid settlement funds, NACo worked with a team of advisors to identify a subset of high-impact strategies that are under county authority. For each of these strategies, NACo is developing concise briefing documents customized to county government. Each brief focuses on a specific opioid abatement strategy and summarizes the available evidence, best practices for implementation, county examples and links to additional resources, including opportunities for specialized technical assistance. This publication contains strategy briefs on select topics; additional strategy briefs are available at www.naco.org/opioid.

BRIEF TOPICS

Medication-Assisted Treatment ("MAT") For Opioid Use Disorder

A NACo Opioid Solutions Strategy Brief: CORE STRATEGY

What is medication-assisted treatment ("MAT") for opioid use disorder?

The Food and Drug Administration (FDA) has approved three medications that safely and effectively treat opioid use disorder (OUD) to improve the health and wellbeing of people living with OUD. MAT is defined by on-going, long-term treatment with one of these three medications.

"Medication-assisted treatment works. The evidence on this is voluminous and ever growing... [F]ailing to offer MAT is like trying to treat an infection without antibiotics."

– Alex Azar II, Secretary of the U.S. Department of Health and Human Services, 2018-2021 [1]

How does MAT with medications for opioid use disorder (MOUD) work?

OUD is characterized by continued opioid use—or feeling incapable of controlling one's opioid use—despite negative consequences such as injury, illness, fractured relationships, arrest or incarceration.

Opioid cravings can pose challenges to people who want to stop or reduce their opioid use. When they do stop, people with OUD may experience withdrawal symptoms, including vomiting, diarrhea, fever, muscle aches, tremors, insomnia, anxiety or depression. Fear and avoidance are normal responses to withdrawal experiences and can be an obstacle for people who want to use less or stop using entirely. The FDA has approved three medications for treating OUD: **methadone**, **buprenorphine** and **naltrexone**. Methadone and buprenorphine work by reducing cravings and preventing withdrawal. Naltrexone works by blocking the effects of opioids in the body.

MOUD can help people living with OUD prevent overdose, achieve abstinence and "feel normal" again. Scan the QR code to hear Chase's story.

METHADONE

(Brand names: DISKETS®, Dolophine®, Methadose®)

Methadone reduces cravings and controls withdrawal symptoms because it is an opioid.

✓ Must be taken daily, though some people need to take methadone twice daily

✓ When used to treat OUD, methadone can only be dispensed by federally registered Opioid Treatment Programs (OTPs)

BUPRENORPHINE

(Brand names: Buprenex® Butrans®, Sublocade®, Suboxone®, Subutex®, and others)

Buprenorphine, sometimes referred to as "bupe," reduces cravings and controls withdrawal symptoms because it is a partial opioid.

✓ Can be taken at home daily OR administered by a clinician as a long-acting injection

✓ Can be prescribed by any qualified* clinician

NALTREXONE

(Brand names: Depade®, Revia®, Vivitrol®)

Naltrexone is an opioid blocker. It prevents opioids from affecting the body.

✓ Can be taken at home daily OR administered by a clinician as a long-acting injection

✓ Can be prescribed by any clinician licensed to prescribe medication[4]

* As of December 9, 2022, any practitioner with current DEA registration that includes the authority to prescribe Schedule III medications may prescribe buprenorphine as allowable by state law. The DATA waiver (X waiver) requirement has been removed.[2-3]

How does *an opioid* treat opioid use disorder?

Methadone and buprenorphine are opioid medications that reduce cravings and withdrawal. Unlike many illicit opioids, these medications have a stabilizing effect which helps to end the constant cycle of craving and withdrawal.

All three medications can be used alone or in conjunction with cognitive or behavioral therapy, intensive outpatient treatment, inpatient (residential) treatment, psychiatric care or other social and healthcare services—as appropriate for each individual person according their needs and circumstances.

Treating OUD with opioid medications (methadone and buprenorphine, specifically) has long been considered the gold-standard of care.[5-6] However, no single medication works well for all. Equal access to all three supports finding the treatment that works best and **patient preference** remains one of the most important factors. All things being equal, the best medication choice may be the one a person is interested in trying or the one they will continue to take.

What evidence supports MAT as a public health strategy?

While all three manage OUD symptoms, only methadone and buprenorphine have been proven to prevent opioid overdose;[7-8] in contrast, evidence is growing that naltrexone increases the risk of overdose among those who take it to treat OUD.[9-10]

METHADONE AND BUPRENORPHINE

Methadone and buprenorphine have been used to treat OUD for decades.

Methadone and buprenorphine work; the evidence is vast, strong and consistent.[5-6]

People with OUD taking prescribed methadone or buprenorphine are **50% less likely to die of overdose** compared to no treatment and compared to those taking naltrexone.[7-8]

Because methadone and buprenorphine are opioids, they reduce cravings and withdrawal symptoms while maintaining opioid tolerance. Maintaining tolerance reduces the risk of death in the event of return to illicit use.

NALTREXONE

Naltrexone has been used for decades to treat alcohol use disorder; it is the newest FDA-approved medication for treating OUD.

Studies show naltrexone to be effective at treating OUD.[9-10]

Individuals prescribed naltrexone are more likely to drop out of treatment in the first 30 days compared to those taking buprenorphine.[11-12]

In 2019, the FDA released a warning about increased risk of overdose after cessation of naltrexone treatment.[13] This risk may exist while someone remains in treatment.[14]

Because naltrexone is not an opioid, people taking it lose their opioid tolerance, which increases risk of harm in the event of return to illicit use.

Are there risks to my community or institution if we don't support access to MAT?

Yes. First, treatment with MOUD—especially methadone and buprenorphine—is in high demand across the United States; yet demand far exceeds availability. People seeking treatment with MOUD often experience long travel-times, insurance barriers, prohibitive out-of-pocket expenses, provider stigma and long waitlists;[15-18] some of these problems worsened during COVID-19.[19] **Many people die waiting to receive treatment.**[20]

Second, failed attempts to access buprenorphine through a healthcare provider is strongly associated with illegally obtained prescription medications to self-treat OUD.[20-21] **Insufficient access to MOUD can lead to diversion and misuse of prescription drugs.**

Third, the Americans with Disabilities Act (ADA) offers protections to people who are receiving treatment for a substance use disorder. **Discrimination against persons receiving treatment for OUD is considered a violation of the ADA and could be grounds for legal action.** Numerous lawsuits have been successfully brought against criminal justice institutions, drug courts, employers, residential programs and healthcare providers for refusal to accommodate persons receiving MOUD, sometimes resulting in settlements in the hundreds of thousands. [22-23]

Are there best practices for supporting or implementing MAT?

- **Support equal access to all three** FDA-approved medications ("We need all 3!") so healthcare providers can reliably access the right tools for the right patients.
- Support access to all three FDA-approved MOUD for people who are incarcerated or under community supervision.[24]
- Get creative. **Support access in rural and underserved areas** via teleheath[25-26] and mobile clinics.[27]

Scan the QR code to see how Project ECHO improves access to MOUD.

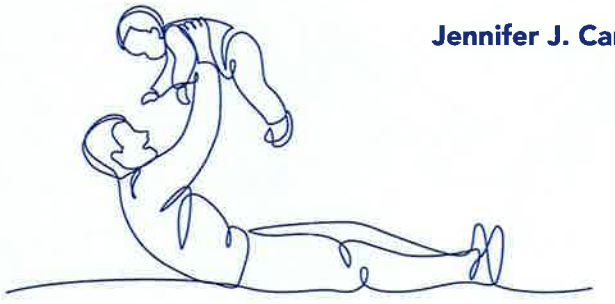
- **Remove cost barriers.** Leverage resources to fund MOUD, cover the out-of-pocket/retail cost for people with limited insurance,[17,28] support continuing MOUD for parenting patients who may lose Medicaid or other coverage after giving birth.[29]
- **Encourage "medication first" policies** that provide MOUD as soon as possible and without conditions (e.g., tapering schedules, mandatory acceptance of other services).[30-33]
- Fight stigma. **Voice strong support for MOUD** as effective treatment for OUD. Stigma and misinformation pose significant barriers to residents getting the care they need.[16]

A Note On Language

You may see Medication Assisted Treatment (MAT) referred to as Medications for Opioid Use Disorder (MOUD) in medical journals and other settings. MAT and MOUD are the same thing. "MAT" was first used to convey that certain medications could "assist" other forms of therapy in promoting recovery. It is true that many people living with OUD benefit from counseling and other therapies while also being treated with medications. However, favor has shifted to using "MOUD" as research shows that these medications provide effective, tangible benefits to people living with OUD even without other forms of counseling. Medications do not only "assist" treatment; medications are a core component of treatment.

ADDITIONAL RESOURCES:

Please visit the Opioid Solutions Center for a curated list of resources, technical assistance opportunities and the sources referenced in this brief.



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Increasing Access To Evidence-Based Treatment

A NACo Opioid Solutions Strategy Brief

What can be done to increase access to evidence-based treatment?

"Medication for opioid use disorder is evidence-based care."

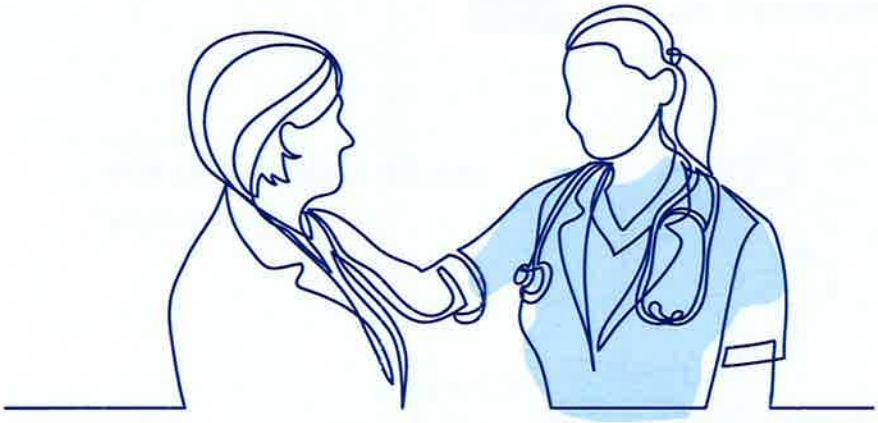
—U.S. Centers for Disease Control and Prevention[1]

The Food and Drug Administration has approved three medications that safely and effectively treat opioid use disorder (OUD): methadone, buprenorphine and naltrexone. However, our healthcare system's capacity to provide medications for opioid use disorder (MOUD) falls far below the current demand for care.[2] Only 1 in 4 people who need MOUD are able to access them.[3]

A multi-pronged approach is needed to build up the treatment workforce, create effective pathways to care and save lives. Counties can reach these goals by:

Expanding treatment capacity: Even the very best referral and diversion systems cannot link people to treatment that doesn't exist.

- The substance use treatment workforce can be expanded by connecting more healthcare institutions and practitioners with the training, support and incentives to prescribe buprenorphine.[4,5]
- Existing clinics can expand treatment capacity by expanding nursing staff,[6,7] encouraging group medical visits,[8] building collaborative care networks with mental health and social services[4,5] and hiring nurse care managers and behavioral health professionals at the county level to coordinate care across local clinics.[9]



Access NACo's Opioid Solutions Strategy Brief on MOUD

Maximizing pathways for treatment engagement: Effective referral systems are guided by the principle that there is "no wrong door" to enter treatment.[10]

- Emergency departments, primary care clinics, jails, harm reduction programs and resource centers can all serve as effective points of contact with treatment services.
- Telehealth options and mobile methadone programs can reduce common barriers to care and reach people in need across larger distances.[11,12]

What evidence supports these strategies for increasing access to evidence-based treatment?

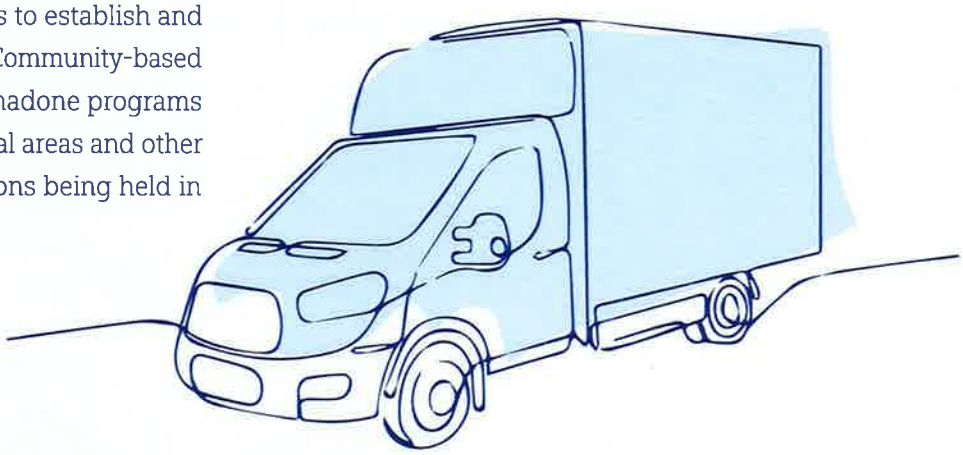
TREATMENT PROVIDERS NEED NURSING SUPPORT: Clinicians are more likely to prescribe buprenorphine if they have sufficient staff support and resources for managing OUD care.[6,13] Adding a nurse care manager to the clinical care team is one of the most impactful facilitators of buprenorphine availability in any healthcare practice;[6,7] it also improves patient engagement and satisfaction with care.[14] In primary care settings, academic detailing has also been proven effective at supporting evidence-based prescribing practices and boosting prescriber confidence.[15-17]

CREATIVE SOLUTIONS BENEFIT PATIENTS AND PROVIDERS: Group visits, also called shared medical appointments, are a long-standing strategy to meet growing demand for healthcare services.[18] Group visits allow clinicians to deliver health care, medication support, peer-to-peer support and group psychotherapy to multiple patients in one setting.[8]

TECHNOLOGY CAN OPEN DOORS: Telehealth options, such as phone or video-based medical appointments, dramatically improve access to MOUD and to mental healthcare. Patients who have access to telehealth tools are more engaged in treatment[12] and are less likely to drop out of treatment early.[19]

PROVIDE CARE WHERE PEOPLE ALREADY ARE: Effective recovery support "meets people where they are at."[20] Telehealth has allowed many syringe service programs (SSPs) across the United States to provide participants with immediate access to buprenorphine, HIV treatment and Hepatitis C treatment.[21-27]

TAKE TREATMENT ON THE ROAD: As of June 2021, DEA rules allow methadone clinics to establish and operate mobile methadone programs.[28] Community-based methadone clinics can use mobile methadone programs to deliver medication to residents of rural areas and other under-resourced settings[29] and to persons being held in prisons and jails.[30]



Are there risks to my community if we don't increase access to evidence-based care?

Yes.

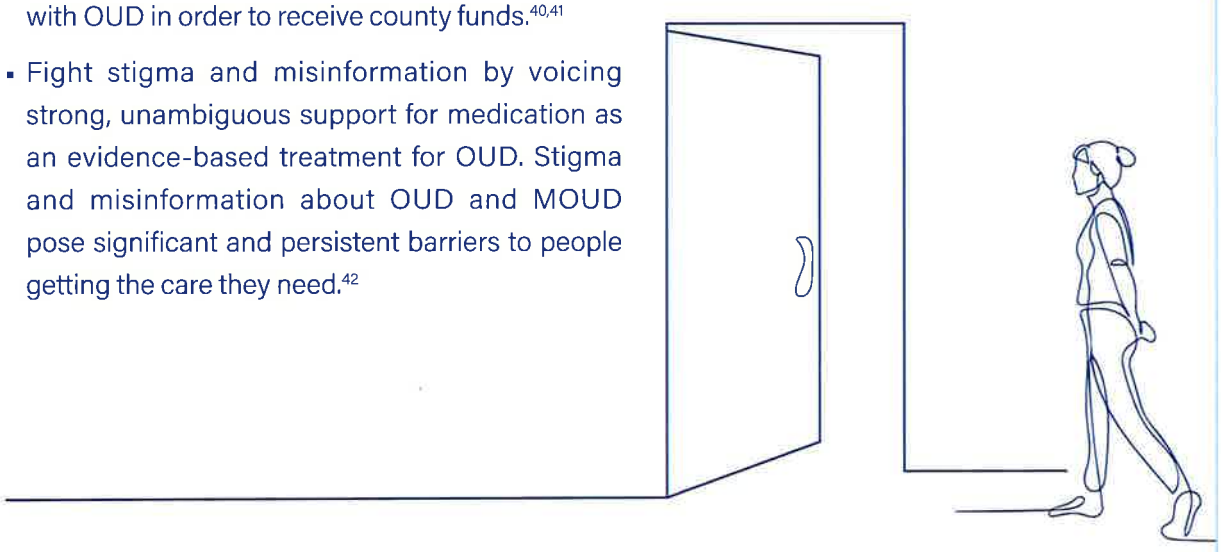
Regions with lower access to evidence-based treatment have the highest rates of OUD and opioid overdose in the country.[31,32]

In 2020, an estimated 2.7 million people over the age of 12 were living with OUD in the U.S.[33] This estimate does not include the approximately 2 million people who are incarcerated[34] (the majority of whom are living with a substance use disorder[35,36]) or the nearly 600,000 people experiencing homelessness.[37]

The greatest unmet need for MOUD is in rural and under-resourced settings. The average American lives 22.7 miles from an MOUD treatment provider.[38] Nearly 40% of rural counties have no local buprenorphine prescriber at all.[31]

What are best practices for increasing access to evidence-based treatment?

- Provide support for programs to implement telehealth services to expand MOUD access or add MOUD treatment to existing telehealth services.[12,19]
- Support local methadone clinics in going mobile by assisting with the costs of vehicles, equipment and staff.[11]
- Support the establishment of "health hubs" at community-based SSPs where clinics offering MOUD can be reached through telehealth and other cooperative arrangements.[39]
- Consider requiring substance use treatment providers to dispense or facilitate access to MOUD for patients with OUD in order to receive county funds.[40,41]
- Fight stigma and misinformation by voicing strong, unambiguous support for medication as an evidence-based treatment for OUD. Stigma and misinformation about OUD and MOUD pose significant and persistent barriers to people getting the care they need.[42]



What are some examples of successful efforts to increase access to evidence-based treatment?

In 2020, the state of Rhode Island created a "buprenorphine hotline" that residents could reach by phone to be connected with a qualified clinician for initial assessment and, if appropriate, an initial buprenorphine prescription and a referral to a community clinic for continued MOUD treatment.[12,43]

In April 2019, the Caroline County Health Department, located on Maryland's eastern Delmarva Peninsula, launched a Mobile Care Unit to provide evidence-based treatment with MOUD to residents in rural and underserved areas of the county.[44,45] The Mobile Care Unit is telehealth equipped to connect with addiction medicine specialists at the University of Maryland School of Medicine in Baltimore in order to provide point-of-care diagnosis, medication initiation and follow-up care.[44]

These and many other model programs are described online at the Brandeis Opioid Resource Connector

The North Carolina Harm Reduction Coalition and Queen City Harm Reduction recently partnered with Duke University's regional healthcare system to provide telehealth access to HIV prevention medication (PrEP), Hepatitis C treatment and OUD treatment (buprenorphine) to SSP participants in North Carolina's New Hanover County and Mecklenburg County, respectively. More than 80% of the patients enrolled in the telehealth clinic were actively seeking MOUD access to reduce their drug use.[46]

Atlantic County Justice Facility, the local jail in Atlantic County, N.J., was among the first in the nation to utilize a mobile methadone program. The facility partnered with John Brooks Recovery Center, a community-based treatment facility and methadone clinic, to provide persons incarcerated in the jail with daily methadone treatment through the Center's mobile methadone van.[47]

ADDITIONAL RESOURCES:

Please visit the Opioid Solutions Center for a curated list of resources, technical assistance opportunities and the sources referenced in this brief.

NATIONAL ASSOCIATION of COUNTIES NACo.

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Treatment and Recovery for Pregnant and Parenting People

A NACo Opioid Solutions Strategy Brief: CORE STRATEGY

"Rather than discouraging discussions of drug use during pregnancy, we should be looking upon them as an opportunity to bring about positive, long-lasting change in the life of the [parent] and child, through effective treatment and support services."

—Loretta Finnegan MD [1]

What is effective treatment for opioid use disorder for pregnant and parenting people?

During pregnancy, the evidence-based standard of care for opioid use disorder (OUD) is treatment with methadone or buprenorphine. These medications for opioid use disorder (MOUD) are safe to use during pregnancy and recommended by the U.S. Substance Abuse and Mental Health Services Administration (SAMSHA),[2] the American Society for Addiction Medicine (ASAM)[3] and the American College of Obstetricians and Gynecologists (ACOG).[4]

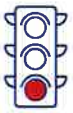
Even though MOUD is the standard of care, many pregnant and parenting people cannot access MOUD through existing healthcare infrastructures.[5,6] In addition, pregnant and parenting people with OUD may avoid the healthcare system out of justified concerns about child welfare involvement and the risk of losing their children.[7-10] Child removal is associated with a greater risk of accidental overdose for the birth parent[11] and entry into the foster system is associated with worse outcomes for the child.[12] Effective treatment for pregnant and parenting people means expanding access to MOUD and adopting a family-centered approach that prioritizes keeping families together.[13,14]

Scan the QR code to watch a short video about Eat, Sleep, Console: a family-centered program for parents and newborns affected by substance use.

What evidence supports treatment with MOUD for pregnant and parenting people?

Methadone and buprenorphine have been used to treat OUD for decades; research consistently supports their effectiveness.[15,16] For people with OUD, receiving these medications during pregnancy improves delivery outcomes[17] and reduces the risk of non-fatal overdose by as much as 97%.[18]

Treating OUD with naltrexone during pregnancy is widely discouraged by medical experts.[2,3,4] Only two of the three FDA-approved MOUD are recommended during pregnancy: methadone and buprenorphine.



Attempted abstinence during pregnancy — whether through medically-assisted detoxification or at-home efforts to quit "cold turkey" — has an 85-90% failure rate.[19,20] It can also increase the risk of overdose, cause fetal distress and precipitate pre-term labor.[3]

Treatment during pregnancy with methadone or buprenorphine does not increase the risk of neonatal abstinence syndrome (NAS), sometimes called neonatal opioid withdrawal syndrome (NOWS). Receiving higher doses of either medication does not increase the severity or duration of NAS symptoms.[21,22] Even if it does occur, NAS is a short-term, manageable condition.[23,24]

Are there risks to my community or institution if we don't support treatment with MOUD for pregnant and parenting people?

Yes. Approximately 1 in 20 pregnant people use drugs,[25] meaning roughly 200,000 infants are born each year exposed to substances. The need for evidence-based treatment and recovery support for pregnant and parenting people is great, but access to MOUD is extremely poor—especially for Black and Hispanic persons of reproductive age[26,27] and in regions most affected by opioid use and overdose.[5] Poor MOUD access for pregnant and parenting people may result in higher social and healthcare costs for managing substance-affected pregnancies.[28,29]

Further, the Americans with Disabilities Act (ADA) offers protections to people who are receiving treatment for a substance use disorder. Discrimination against persons receiving MOUD treatment—including pregnant and parenting people—is considered a violation of the ADA and could be grounds for legal action.[30]

What are best practices to support treatment and recovery for pregnant and parenting people?

- As your state laws allow, **develop a template for Plans of Safe Care** for use by relevant child welfare agencies providing care for substance-affected pregnancies in your county in accordance with the Child Abuse and Prevention Treatment Act of 2016 (CAPTA). Plan of Safe Care templates help coordinate better support for families impacted by substance use and reduce unnecessary engagement with child welfare services.[31]

- **Help secure funds to cover the cost of medications** for pregnant and parenting people who may lose access to health coverage (including Medicaid) shortly after giving birth.[32–34]

- **Support access to MOUD in rural or underserved areas** by promoting telehealth,[35] mobile clinics[36] and other innovative approaches to serve pregnant and parenting people.[37]

- **Expand free and affordable family housing options** for pregnant and parenting people receiving treatment for OUD.[14]

- **Fight stigma and misinformation** by voicing strong support for MOUD as an evidence-based treatment for OUD during and after pregnancy. Stigma and misinformation about OUD and MOUD pose significant and persistent barriers to people getting the care they need.[38]

What are some examples of successful treatment and recovery programs for pregnant and parenting people?

These and many other model programs are described online at the Brandeis Opioid Resource Connector.

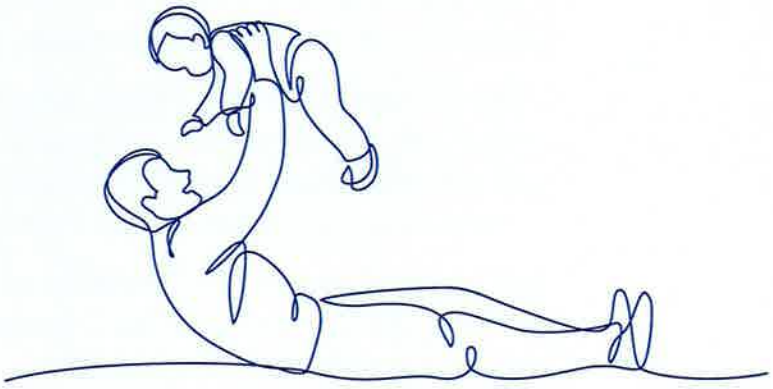
Project CARA (Care that Advocates Respect/Resilience/Recovery for All) is a program of the Mountain Area Health Education Center, which serves pregnant people with substance use disorders in 20 western Appalachian counties in North Carolina. Project CARA provides trauma-informed perinatal healthcare that includes MOUD treatment alongside wraparound services to address housing, transportation, food security and other social determinants of health.[39]

The Pregnancy Recovery Center at the University of Pittsburgh's Magee-Women's Hospital offers MOUD to pregnant people through patient-centered delivery of care. The Pregnancy Recovery Center care team consists of obstetric and gynecological physicians who are licensed to prescribe buprenorphine, a nurse with addiction medicine training and a social worker.[40]

The Maternal Opiate Medical Support (MOMS) initiative in Ohio offers MOUD to people living with OUD both during and after pregnancy through a medical care home model. MOMS also provides access to residential treatment—when residential care is indicated—that allow parents and children up to 12 years of age to continue living together.[41]

ADDITIONAL RESOURCES:

Please visit the Opioid Solutions Center for a curated list of resources, technical assistance opportunities and the sources referenced in this brief.



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Treatment for Neonatal Abstinence Syndrome

A NACo Opioid Solutions Strategy Brief: CORE STRATEGY

"Collaborative planning and implementation of services that reflect best practices for treating opioid use disorders during pregnancy are yielding promising results in communities across the country."

—U.S. Substance Abuse and Mental Health Services Administration[1]

What is Neonatal Abstinence Syndrome?

Approximately 1 in 20 people who become pregnant use drugs during pregnancy.[2] This translates to roughly 200,000 substance-exposed infants each year.

Neonatal Abstinence Syndrome or NAS (also called Neonatal Opioid Withdrawal Syndrome or NOWS) is a condition that sometimes affects newborns of parents who have taken opioids during pregnancy. In the absence of other health complications, NAS is a short-term condition that can be simple and inexpensive to treat[3,4] and poses no risks of long-term cognitive or physical deficit to the child.[5,6]

NAS is an expected outcome for the infants of parents who received medications for opioid use disorder (MOUD), the gold standard treatment for opioid use disorder (OUD), during pregnancy. However, because NAS does not cause long-term health consequences, treatment with MOUD – as opposed to withdrawal and abstinence – is safer for both parents and their infants.

What are effective treatments for NAS?

Opioid-affected parents and their newborns are best served by treating parents and newborns as a unit.[7] This family-centered approach to care includes:

- MOUD treatment for the parent during pregnancy and after delivery;[8,9]
- Rooming in, or placing parents and infants in the same hospital room;[10]
- System-wide adoption of the eat-sleep-console model of NAS care; and
- Wraparound psychological and social support services for the parent or parents;[8]

Family-centered care does not include punitive responses to substance use for pregnant or parenting people, such as civil or criminal sanctions, as these invite greater health risks for both parents and infants.[4,8]

What evidence supports treating parents and newborns with NAS as a unit?

Treating OUD with methadone and buprenorphine during pregnancy is encouraged by the American Society for Addiction Medicine (ASAM),[9] the American College of Obstetricians and Gynecologists (ACOG)[8] and the American Academy of Pediatrics.[11] Treatment with MOUD during pregnancy significantly reduces the risk of preterm birth[12] and virtually eliminates the risk of non-fatal overdose during pregnancy.[13]

Infants with NAS are not at risk of long-term physical or cognitive harm. There is no evidence linking fetal exposure to opioids (including MOUD[14]) to long term cognitive deficits,[5] negative birth outcomes[6] or other complex medical conditions[15] in the child born of that pregnancy.

The eat-sleep-console model is an evidence-based, in-patient model of postpartum care for families affected by NAS. The eat-sleep-console model is proven to reduce the length of hospital stays and reduce the use of withdrawal management medications for newborns, cutting the cost of hospital stays in half.[10,16–19]

The Eat-Sleep-Console Model is a standardized approach to NAS.[20–22]

SIMPLIFIED ASSESSMENT

EAT: Can the newborn eat ≥1 ounce per feed?

SLEEP: Can the newborn sleep ≥1 hour at a time?

CONSOLE: Can the crying newborn be consoled within 10 minutes?

If the answer to all of these questions is yes, the newborn is considered well-managed and no further intervention is needed.

NON-MEDICATION INTERVENTIONS

- Low-stimulation environment (dimmed lights, reduced noise)
- Rooming-in with the parent(s)
- Parental presence
- Skin-to-skin contact
- Cuddling or holding by a caregiver or volunteer
- Swaddling
- Feeding on demand (breast-feeding when possible)
- Hospital staff continuously engages and supports parents in the care of their newborns

OTHER COMPONENTS

Prenatal counseling to help parents know what to expect after delivery.

Train staff to support non-medication interventions and communicate empathetically with parents.

Morphine as needed and only as a second-line treatment if non-medication interventions fail.

Empower parents to see themselves as their newborn's best treatment.

A family-centered approach to care treats infants and their parent(s) as a unit whose health is interconnected. It preserves the parent-infant bond and supports optimal health outcomes.[10] Removing or threatening to remove infants from their parent(s) may increase lifetime risk of drug use, criminal justice involvement and other adverse outcomes for the child..[23] Child removal also puts birth parents at greater risk of overdose.[24]

Are there risks to my community or institution if we don't use approaches that treat parents and newborns with NAS as a unit?

Yes.

Earlier approaches to NAS, like separating parents and infants, placing infants in neonatal intensive care units and using morphine as a first-line treatment for infants, require longer hospital stays and are generally more expensive than the eat-sleep-console approach.[25] This can impose significant burdens on the personnel and financial resources of local hospitals.

Further, discrimination against persons receiving MOUD treatment, including pregnant and parenting people, is considered a violation of the Americans with Disabilities Act (ADA) and could be grounds for legal action. The U.S. Department of Justice has entered into legal settlements and arrangements with several healthcare and child welfare systems for failing to accommodate persons receiving MOUD, sometimes resulting in civil monetary penalties paid to the persons affected.[26]

Are there best practices for addressing the needs of infants with NAS and their parents?

- Support local hospitals with implementing the eat-sleep-console model:
  - Provide funding and support for staff education through remote services like Project ECHO.[27]
  - Encourage use of an Eat-Sleep-Console Care Tool as part of the system-wide implementation strategy.
  - Consider configuring hospital facilities to support rooming-in as a standard of care for all birth families.

Watch how healthcare providers in Spokane, Wash. are using Eat-Sleep-Console to treat NAS with fewer or no medications and shorter hospital stays.

- Build relationships with healthcare providers, child welfare professionals and other relevant stakeholders to support collaborative care models during the perinatal period and as the children grow.[28,29]
- Develop a template for Plans of Safe Care in accordance with the Child Abuse and Prevention Treatment Act of 2016 (CAPTA), as state laws allow, to reduce child-welfare involvement and improve health outcomes for the whole family.[30]

- Expand free and affordable family housing options for pregnant and parenting people receiving treatment for OUD,[31] including (but not limited to) residential treatment options that allow parents and their children to reside together.
- Fight stigma and misinformation by voicing strong, unambiguous support for MOUD during and after pregnancy, and by raising awareness that NAS is a short-term and relatively easy-to-manage condition.[4,32]

What are some examples of programs successfully meeting the needs of infants with NAS and their parents?

These and many other model programs are described online at the Brandeis Opioid Resource Connector.

The Yale New Haven Children's Hospital was the first to implement the eat-sleep-console model. As a result, the percent of infants with NAS receiving morphine dropped from 98% to 14%, and the infants' average length of stay dropped from three weeks to 6 days.[20]

Enhancing Permanency in Children and Families (EPIC) is a multi-agency, coordinated system of care in Ohio that provides substance-involved families with peer recovery supports, incentivized participation in family treatment court, access to MOUD and home-based parenting support.[33]

The Department of Social Services in Buncombe County, N.C. operates the Sobriety Treatment and Recovery Team (START) Program. START pairs Child Protective Services (CPS) professionals trained in family engagement with peer support specialists who have lived experience undergoing a CPS case. These teams are embedded at local hospitals to support in-home placement, improve parental engagement, accelerate linkage with evidence-based substance use treatments for parents and keep families together.[34]

ADDITIONAL RESOURCES:

Please visit the Opioid Solutions Center for a curated list of resources, technical assistance opportunities and the sources referenced in this brief.

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NATIONAL ASSOCIATION of COUNTIES NACo.

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Effective Treatment For Opioid Use Disorder For Incarcerated Populations

A NACo Opioid Solutions Strategy Brief: CORE STRATEGY

What is effective treatment for opioid use disorder for people who are incarcerated?

"Individuals who are incarcerated are a vulnerable population and withholding evidence-based opioid use disorder treatment increases risk of death during detainment and upon release."

—American Society for Addiction Medicine[1]

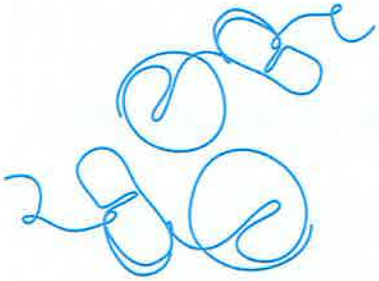
Medication-assisted treatment (MAT) is considered the "gold standard" of care for opioid use disorder (OUD).[1-3] The FDA has approved three medications for treating OUD (MOUD): **methadone**, **buprenorphine** and **naltrexone**.

The American Society for Addiction Medicine (ASAM) and the National Commission on Correctional Health Care (NCCHC) fully endorse treatment with MOUD in all criminal justice settings.[1,4]

Evidence-based OUD treatment for persons who are incarcerated consists of:

- Offering MOUD treatment initiation for those with OUD who were not receiving it prior to incarceration;
- Continuing treatment with MOUD for those who were receiving it prior to incarceration;
- Continuing MOUD treatment for the duration of incarceration (unless the patient requests to stop); and
- Working to prevent interruptions to MOUD treatment during intake, transfer or release.[5]

Treatment with MOUD can be combined with cognitive or behavioral therapy, psychiatric care or other forms of psychosocial support. Still, treatment with MOUD should be provided even in settings where these services are not available.[6]



"No justification exists for denying access to [MOUD] because psychosocial services are unavailable or individuals are unwilling to avail themselves of those services."

-U.S. Substance Abuse and Mental Health Services Administration[6]

What evidence supports treatment with MOUD for people who are incarcerated?

Long-term treatment with MOUD in correctional settings is safe, feasible and effective at reducing overdose deaths.[7,8] Short-term use of these medications for tapers or withdrawal management is not recommended and can increase a person's risk of overdose upon release.[9,10]

Disruptions in treatment are harmful

Individuals who are forced to discontinue MOUD upon entering the justice system are significantly less likely to engage with effective treatment in the future.[5]

Choice matters

Some jails provide naltrexone, but not methadone or buprenorphine, upon release. This goes against ASAM and NCCHC recommendations[1,4] and is associated with increased risk of overdose[11,12] and treatment drop-out.[13]

Incarceration is a primary risk factor for overdose[14]

In the first two weeks after release, the risk of opioid overdose is **40 times higher** for those who were incarcerated compared to the general population.[15]

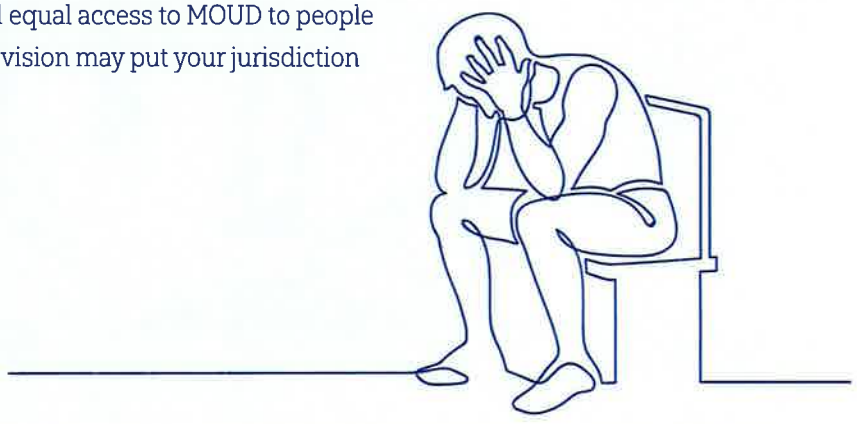
The FDA acknowledges that cessation of naltrexone treatment increases someone's risk of overdose.[16]

Are there risks to my community or institution if we don't support treatment with MOUD for people who are incarcerated?

Yes. Treatment with MOUD—specifically, with methadone or buprenorphine—is the most effective way to prevent opioid overdose among people living with OUD.[17,18] Because incarceration is a known driver of opioid overdose,[11] failure to provide this gold standard of care to criminal justice-involved persons may exacerbate health risks in your community.

Federal Courts have ruled that jails and prisons are bound by Title II of the Americans with Disabilities Act (ADA) and the Eighth Amendment to provide access to all three FDA-approved medications for the initiation or continuation of MOUD during incarceration.[19] Failure to provide immediate and equal access to MOUD to people who are incarcerated or under community supervision may put your jurisdiction at risk of significant financial or legal liability.

Being denied MOUD while incarcerated can be painful, frightening and traumatic.



Are there best practices for providing treatment with MOUD for people who are incarcerated?

- **Ensure equal access to all three** FDA-approved medications so healthcare providers can reliably access the right tools for the right patients.[6]
- **Prevent interruptions in treatment** for those who were receiving MOUD prior to incarceration.[5] In 2021, NACo members passed a resolution urging congress to end Medicaid's Inmate Exclusion Policy in the Federal Social Security Act; ending this exclusion would reduce treatment interruptions in correctional settings.[20]
- **Coordinate with local Opioid Treatment Programs (OTPs)** that provide methadone. The U.S. Drug Enforcement Administration's new "mobile methadone" rule allows community-based OTPs to dispense methadone to incarcerated persons via mobile units.[21,22]
- **Partner with local healthcare providers** to seamlessly link persons who are incarcerated or re-entering the community with long-term MOUD treatment.[23,24]
- **Help secure funding so that county agencies and community-based service providers can cover the cost of medications** for those who are un- or underinsured, as out-of-pocket cost is a common barrier to treatment with MOUD.[25,26]
- **Fight stigma and misinformation** by voicing strong support for evidence-based treatment with MOUD throughout the criminal justice systemx. Stigma and misinformation pose significant and persistent barriers to providing adequate treatment within the criminal justice system.[27,28]

What are some examples of effective treatment programs for people who are incarcerated?

These and many other model programs are described online at the Brandeis Opioid Resource Connector.

Rikers Island Correctional Facility, New York City's jail, has successfully operated a methadone and buprenorphine program since 1987. Today, the facility provides access to all three FDA-approved MOUD.[29]

Atlantic County Justice Facility, the local jail in Atlantic County, N.J., was among the first in the nation to utilize a mobile OTP. The facility partnered with John Brooks Recovery Center, a community-based treatment facility and OTP, to provide persons incarcerated in the jail with daily methadone treatment through the Center's mobile methadone van.[30]

In 2022, the Chesterfield County Jail in Chesterfield County, Va. added a MAT program to its substance use service offerings, which include a previously established abstinence-based recovery program. By creating a designated pod for persons receiving MOUD, the Supported Medically Assisted Rehabilitative Treatment (SMART) program provides continued treatment with methadone or buprenorphine for persons entering the jail as well as long-term recovery supports.[31]

Since 2008, the Philadelphia Department of Prisons has screened all persons entering the Curran-Fromhold Correctional Facility for OUD. Those in need of MOUD are immediately referred to the jail's in-house MAT program, which offers all three FDA-approved MOUD. Upon release, those receiving MOUD inside the jail receive assistance obtaining health insurance, a warm hand-off to an MOUD prescriber in the community and a short-term supply of medication to "bridge" the gap between release and the first appointment with a new health care provider.[32] Scan the QR code to watch a short video about the medication-assisted treatment program in Philadelphia's Curran-Fromhold Correctional Facility, which begins with immediate clinical intake and ends with continued care in the community.[32]

ADDITIONAL RESOURCES:

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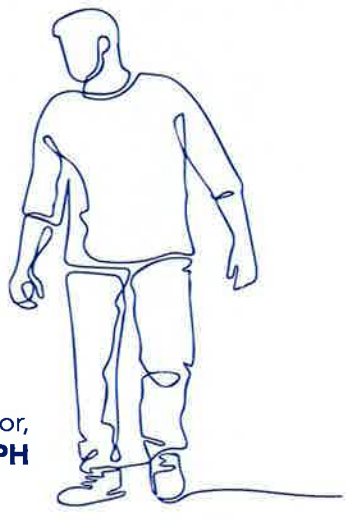

NATIONAL ASSOCIATION of COUNTIES NACo.

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Naloxone To Reverse Opioid Overdose

A NACo Opioid Solutions Strategy Brief: CORE STRATEGY

"Focus on things that actually work: medications, providing naloxone and syringe service programs."

—Michael Botticelli, Director of the Office of National Drug Control Policy, 2014-2017[1]

What is naloxone?

Naloxone is a "rescue" drug that quickly and safely reverses opioid overdose. It is available as an injectable solution and as a nasal spray. Naloxone works by blocking the effects of opioids in the body.[2] Virtually all opioid overdose deaths are preventable if naloxone is administered in time.

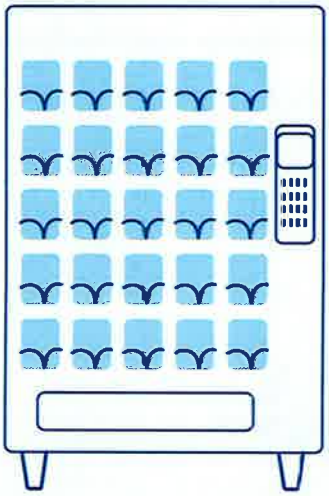
Scan the QR code to hear from individuals and families about the importance of naloxone.

A person who has overdosed cannot administer naloxone to themselves — it must be administered by someone else nearby. The most effective way to prevent fatal opioid overdose with naloxone is to prioritize naloxone distribution to people who use drugs[3,4] (for example, through harm reduction and syringe services programs) as this group is the most likely to witness an overdose.[5,6]

Distributing naloxone to the public at pharmacies is also highly effective.[3,7] All states but one (Neb.) allow pharmacists to prescribe or dispense naloxone to anyone.[8]

Other new and innovative methods for naloxone distribution include:

- Publicly accessible "NaloxBoxes,"[9]
- Vending machine distribution,[10]
- Naloxone distribution by mail[11] and
- Naloxone leave-behind programs led by Emergency Medical Services (EMS) professionals.[12]



What evidence supports naloxone to reverse opioid overdose?

NALOXONE SAVES LIVES Opioids produce their effects on the body (including pain relief and slowed breathing) by attaching to and activating certain receptors in the brain.[13] Naloxone is able to reverse opioid overdose by blocking those receptors and preventing opioids from attaching.[2]

NALOXONE EFFECTIVELY BLOCKS ALL OPIOIDS Although certain opioids, like fentanyl, produce stronger effects on the body, they do not require more naloxone to counteract.[14,15] Multiple studies have demonstrated that the same amount of naloxone works to reverse opioid overdose regardless of fentanyl exposure.[16,17]

NALOXONE ACCESS SAVES LIVES Between 1996 and 2014, syringe services programs across the U.S. distributed over 150,000 naloxone kits, resulting in tens of thousands of opioid overdose reversals by community members.[18] The reach of naloxone access programs has since expanded. For example, North Carolina received reports of 4,152 successful community overdose reversals with naloxone in the year 2021 alone.[19]

Watch a short video about NC Harm Reduction Coalition's naloxone distribution model

NALOXONE DOES NOT WORSEN SUBSTANCE USE Common myths about naloxone are that it encourages drug use and discourages people who use drugs from seeking treatment.[20,21] These claims are untrue; multiple studies have found no association between naloxone access and worsening patterns of substance use.[22-25]

WHAT ARE NALOXONE ACCESS LAWS? In response to rising overdose rates, states have implemented laws that make it easier for members of the public to access naloxone. State naloxone access laws vary, but many states have established a standing order that authorizes the dispensing of naloxone to persons meeting set criteria.[26] Naloxone access laws are associated with lower rates of fatal opioid overdose.[7,27-30]

Are there risks to my community or institution if we don't support naloxone to reverse opioid overdoses?

Yes.

NALOXONE ACCESS LAWS DO NOT GUARANTEE NALOXONE ACCESS[7]
County leaders can help ensure that local residents successfully obtain the naloxone needed to save lives by providing institutional and financial support for naloxone access programs.

WITHOUT NALOXONE NEARBY, THERE MAY BE MORE OVERDOSE DEATHS
Though most first responders already carry naloxone,[20,31] the fastest way to reverse an overdose is to ensure that the person on scene when the overdose occurs (usually someone else who uses drugs[5,6]) has naloxone on hand before the overdose occurs.

How much naloxone do we need?

The amount of naloxone each community needs depends on a number of local factors. The website **NaloxoneNeededToSave.org** provides evidence-based estimates of the quantity of naloxone each state needs to achieve naloxone saturation.

State and federal block grants support the purchase of naloxone by public safety and public health agencies, but this may not be enough. One study compared naloxone access in 12 states and found that only one state met the national target for naloxone access.[3]

Remedy Alliance for the People is a non-profit organization that negotiates with pharmaceutical companies to provide community-based organizations, health departments and other entities with lower prices for generic injectable naloxone.[32]

In September 2022, the U.S. Food and Drug Administration issued new guidance that explicitly permits the bulk purchase of naloxone for harm reduction programs regardless of whether or not the purchaser is covered by a statewide standing order or a medical license.[33]

As of March 29, 2023, nasal spray naloxone (Narcan) is classified by the FDA as an over-the-counter medication.[34]

What are best practices for supporting or implementing naloxone to reverse opioid overdoses?

- Increase the local supply of naloxone by funding procurement or coordinating local or regional stockpiles.
- Provide funding and voice strong, unambiguous support for programs and sites that distribute naloxone. High-volume distribution though syringe services programs is typically the most effective strategy for preventing overdose death with naloxone.[3]
- Prioritize naloxone distribution to recently incarcerated persons and their social networks. Recently incarcerated people are at high risk of overdose[34,35] and regularly use naloxone to save lives.[36,37]
- Reduce mandatory training requirements for those who distribute naloxone. About five minutes is all that's needed to deliver successful and effective naloxone training.[38,39]
- Educate local pharmacies about naloxone access laws and dispensing naloxone to the community. Despite new regulations allowing pharmacists to dispense naloxone, levels of pharmacy distribution remain low.[40] Reasons may include: poor understanding of naloxone access laws; not keeping naloxone in stock; and stigma against naloxone or people who use drugs.[41,42]
- Support policies that treat naloxone as a public health tool, not drug paraphernalia. Naloxone possession should be encouraged and does not indicate criminal activity.

What are examples of successful naloxone distribution programs?

These and many other model programs are described online at the Brandeis Opioid Resource Connector.

The first large scale effort to distribute naloxone to people who use drugs was pioneered by Dan Bigg at the Chicago Recovery Alliance in 1996.[43]

In Anne Arundel County, Md., the department of health offers free, ongoing trainings to teach community members how to administer intranasal naloxone. Led by the county's Overdose Response Coordinator, the trainings are held a few times per month and equip each participant with a naloxone kit to take with them into the community.[44]

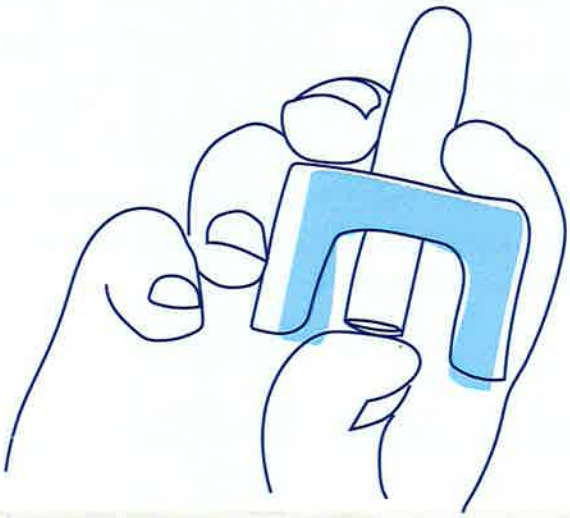
In 2022, the San Diego County Board of Supervisors unanimously approved a resolution to provide overdose prevention education and naloxone distribution in schools. The Board's action will educate students and their parents about overdose risks and increase the availability of naloxone among student and parent first responders.[45]

Rikers Island Correctional Facility, New York City's jail, distributes naloxone to community members who come to the jail for visitation. In the first six months of this program, 20% of the 226 visitors who received naloxone witnessed an overdose, and most used that naloxone to reverse the overdose and save a life.[37]

Project DAWN (Deaths Avoided with Naloxone), an initiative coordinated by the Ohio Department of Health, provides naloxone supplies to a diverse network of hundreds of organizations providing overdose education and naloxone distribution in communities.[46]

ADDITIONAL RESOURCES:

Please visit the Opioid Solutions Center for a curated list of resources, technical assistance opportunities and the sources referenced in this brief.



NATIONAL ASSOCIATION of COUNTIES NACo

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Syringe Services Programs

A NACo Opioid Solutions Strategy Brief: CORE STRATEGY

"High-quality syringe services programs can prevent the spread of disease, save lives, and connect people to other health services, including treatment for substance use disorder."

—Dr. Rahul Gupta, Director of the Office of National Drug Control Policy [1]

What are syringe services programs?

Syringe Services Programs (SSPs) provide low-barrier access to sterile supplies for safer substance use, naloxone and overdose prevention tools like fentanyl test strips and drug checking services. SSPs also provide a range of other services, such as options for safe syringe disposal, overdose recognition and response training and help accessing services for HIV, substance use disorders and more.[2,3]

Community-based SSPs are often led by people with lived experience of substance use who are committed to a harm reduction philosophy and foster a non-judgmental environment for people who are seeking support for their substance use but face discrimination, financial barriers or other challenges when interfacing with other healthcare institutions.[2]

What evidence supports SSPs as a public health strategy?

SSPS PREVENT OVERDOSE SSPs are very effective at providing low barrier access to evidence-based overdose prevention tools, like naloxone[4] and fentanyl test strips.[5,6] SSPs are also very effective at linking people to medication for opioid use disorder (MOUD), which reduces the risk of overdose.[7,8]

The evidence that SSPs prevent overdose is so great that the CDC has endorsed SSPs as one of the most effective, scientifically proven overdose prevention strategies.[2]

SSPS LINK MANY PEOPLE TO SUBSTANCE USE DISORDER TREATMENT
Studies have found that people who participate in local SSPs are significantly more likely to enter treatment for substance use disorder compared to those who do not.[7,9,10] Many SSPs collaborate with healthcare providers to offer MOUD treatment in-person or via telehealth.

SSPS REDUCE SUBSTANCE USE As many as 4 in 5 SSP participants are interested in reducing or ceasing their substance use.[9] SSP participants are more than twice as likely to reduce the frequency of their substance use and more than three times as likely to stop using substances entirely compared to those who do not.[10]

Scan the QR code to view a video tour of Streetwork, an SSP in New York City, and hear from staff and program participants.

SSPS PREVENT DISEASE Access to sterile supplies significantly reduces the transmission of infectious disease, such as HIV and hepatitis C, and prevents potentially life-threatening bacterial infections causing abscess, endocarditis and sepsis.[2]

SSPS REDUCE CRIME AND MAKE NEIGHBORHOODS SAFER SSPs reduce the amount of syringe litter in the neighborhoods where they operate by providing multiple options for safer disposal.[11,12] SSPs do not increase or promote criminal activity[13,14] and have been linked to crime reduction in cities like San Francisco.[15]

Are there risks to my community or institution if we don't support SSPs?

Yes. **MORE FATAL OVERDOSES MAY OCCUR** Though it is possible to obtain naloxone through other means, such as a physician or pharmacy, research is clear that SSPs are the most effective way to distribute naloxone to those most likely to save a life by using it. One study found that pharmacies would have to distribute more than twice as many naloxone kits as community-based SSPs to prevent the same number of overdose fatalities.[4]

HIV OUTBREAKS MAY OCCUR Recent HIV outbreaks in Indiana, Massachusetts and West Virginia have been linked to local policies restricting access to SSPs (such as limited hours, proof of residency requirements, distribution limits or outright SSP bans).[16–18] In addition to being a serious public health crisis, HIV outbreaks are expensive: each new case costs more than $350,000 to treat over a single lifetime.[19]

FEWER PEOPLE WILL ACCESS TREATMENT FOR SUBSTANCE USE DISORDERS SSPs are the most effective and well-trafficked pathway to effective treatment for substance use disorders. People who utilize SSP services are many times more likely to begin treatment, stay in treatment and cease substance use than those who do not.[7–10]

What laws and policies present barriers to SSP services?

As of June 2022, 13 states have laws that bar SSPs from operating and many more have drug paraphernalia laws that criminalize possession of public health supplies that SSPs distribute – including sterile syringes (39 states and the District of Columbia) and fentanyl test strips (44 states and the District of Columbia). SSP bans and drug paraphernalia laws that target safer use supplies undermine the public health benefits of SSPs.[20]

Scan the QR code to view a map of the legal status of SSPs in each state.

What are best practices to support SSPs and related services?

- **Help secure funding for SSP operations.** Lack of funding is a common and significant barrier to SSP operations.[21] Access to a diversity of funding streams can strengthen SSPs and ensure the availability of robust, reliable services over time.[22,23]
- **Help secure funding for the purchase of naloxone.** The amount of naloxone distributed across the United States is far below the levels needed to ensure that most accidental overdoses can be reversed.[4] Funding naloxone procurement for SSPs can reduce overdose deaths.
- **Support needs-based distribution policies**. Limiting the number of supplies an SSP can distribute is unnecessary and harmful.[24,25] One-for-one exchange policies have been implicated in HIV outbreaks.[26,27]
- **Prioritize SSPs led by people with lived experience** of substance use and/or substance use disorder.[2,22] Involving people with lived experiences in the planning, implementation and evaluation of SSPs is a CDC-endorsed best practice[22] and is strongly encouraged in a number of federal funding opportunities.[28]
- **Help secure funding for the purchase of multiple forms of safer use equipment.** SSPs are highly effective at preventing overdose and linking people to treatment.[3] To make these services inclusive to all people who use drugs, SSPs must be able to procure safer use equipment for various forms of use (e.g., injection, smoking). [29,30]
- **Help secure funding for drug checking services** at SSPs. Fentanyl test strips and point-of-service drug checking are newer, evidence-based strategies for preventing fatal overdose.[5,6,31]
- **Fight stigma by voicing strong support for SSPs** and other harm reduction services.[32,33] Stigma and misinformation about SSPs and other harm reduction services pose significant and persistent barriers to implementing this evidence-based strategy.[32,33]
- **Consider policies that legalize possession of public health supplies** distributed by SSPs.

What are some examples of successful SSPs?

These and many other model programs are described online at the Brandeis Opioid Resource Connector.

The Eastern Band of Cherokee Indians established the Tsalagi Public Health SSP in 2018. In addition to providing access to sterile supplies and naloxone, the SSP has linked nearly 1 in 14 participants to treatment for substance use disorders.[34]

Sonoran Prevention Works (SPW) is a nonprofit harm reduction organization founded by people who use drugs. In addition to operating three urban service locations, SPW conducts community-informed outreach programs in Arizona's southern and rural counties. In 2021, SPW trained over 1,000 individuals in harm reduction best practices for overdose prevention and naloxone administration in Cochise, Graham and Santa Cruz counties and distributed nearly 2,500 naloxone kits in these communities.[35]

Prevention Point Philadelphia is an SSP in Philadelphia's Kensington neighborhood. In addition to other essential public health services, like access to naloxone and sterile supplies for safer substance use, Prevention Point also offers MOUD treatment onsite.[36]

The North Carolina Harm Reduction Coalition offers mobile SSP services in several North Carolina counties, expanding access to rural areas of the state where community members face long travel times and other barriers to seeking services often clustered in urban areas.[37]

ADDITIONAL RESOURCES:

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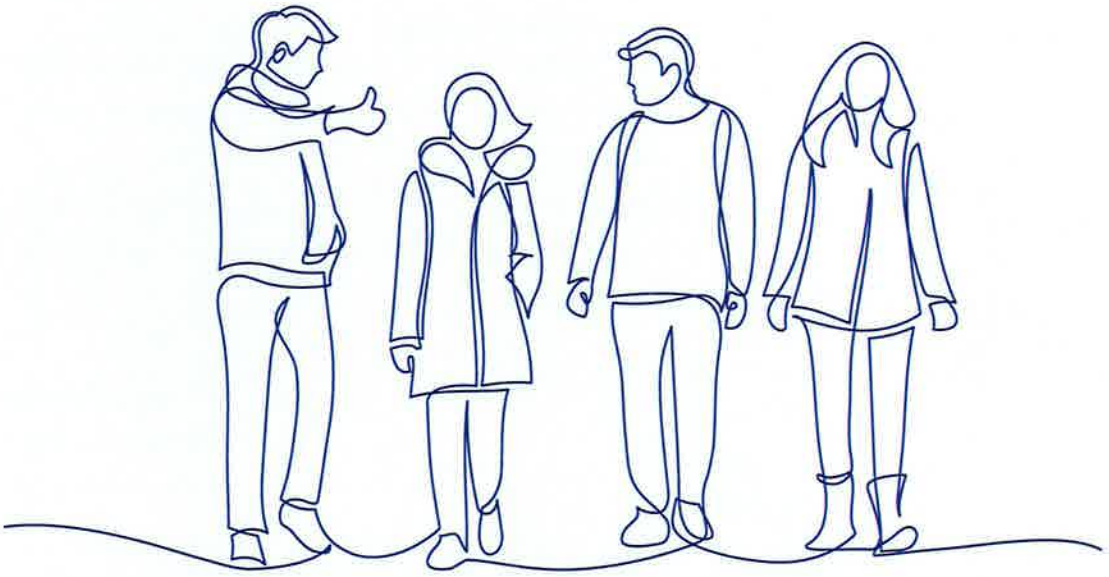

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Post-Overdose Response Teams

A NACo Opioid Solutions Strategy Brief

What are post-overdose response teams?

"Our agenda is to provide care and support to those who need it, that's it."

—Claire Hubbard, Buncombe County, N.C. Post-Overdose Response Team

Post-overdose response teams (also called quick response teams or post-overdose outreach programs) conduct outreach and offer services to people who have experienced an overdose within about 72 hours of the overdose event.[1] Teams consist of two or three health-related professionals, such as harm reduction professionals, outreach specialists, peer recovery specialists, healthcare professionals or emergency medical services (EMS) personnel. Teams can be coordinated by county agencies (e.g., health departments) or by community-based organizations (e.g., harm reduction organizations) operating in partnership with county agencies.

The goal of post-overdose response teams is to prevent future overdose events by connecting the person who overdosed and their immediate friends and family with:

- Evidence-based overdose prevention tools, such as naloxone, fentanyl test strips and harm reduction services;
- Information about and warm handoffs to social services, such as housing, food and nutritional assistance and employment support; and
- Evidence-based treatment and recovery services.

If EMS and other advanced practice providers join the team, they can administer buprenorphine, a medication for opioid use disorder (MOUD), during the outreach visit as appropriate.[2]

See how peer recovery coaches effectively initiate recovery services in emergency departments.

What evidence supports post-overdose response teams as an effective opioid response strategy?

Post-overdose response teams are proven to link people with social services and evidence-based treatment better than point-of-service referrals (e.g., providing a person in need with the number of a hotline to call on their own) or warm hand-offs alone if the outreach participants meet the following criteria:

- Were previously screened for substance use disorder (SUD) or initiated onto treatment with buprenorphine in an emergency room;
- Expressed interest in substance use treatment; and
- Consented to a follow-up visit by a post-overdose response team.[3-6]

As of February 2023, only post-overdose response programs that connect overdose survivors to social services have been associated with community-level reductions in overdose.[7]

> The cities of Houston, Texas and Greenville, S.C. have implemented similar post-overdose response programs. Teams in both cities conduct outreach to patients who were previously screened for SUD or received substance use counseling at the emergency department after presenting with a substance use-related concern.[4,5] This type of follow up increases the likelihood that patients will engage in treatment after receiving a referral in the emergency department.[4,5]

If post-overdose response teams aim to connect people with treatment, screening possible outreach candidates for indicators of SUD is an important step. As many as half of all people treated for accidental overdose do not have a SUD[4] and will not be helped by substance use treatment. However, post-overdose response teams can decrease the risk of subsequent overdose for all outreach participants by providing naloxone and other harm reduction services.[8]

Are there risks to my community if we don't implement post-overdose response teams?

Potentially.

Most post-overdose response programs have not been rigorously evaluated, so it is not entirely clear what benefits may be gained or lost through post-overdose response teams. Some programs have demonstrated effectiveness at connecting people to — and keeping them engaged in — treatment, but only if candidates for post-overdose response are first engaged in an emergency department or carefully screened for SUD and treatment readiness.[3-5]

Evidence is clear, however, that improperly implemented post-overdose response teams can cause harm by:

- Subjecting people who have experienced an overdose and their family members to additional trauma by sending non-health-related personnel or inadequately trained team members to their homes;[9]
- Placing people with SUD at increased risk of arrest and incarceration,[10,11] which increases overdose risk;[12]
- Using coercive strategies to mandate entry into treatment;[9,10] or
- Directing people to treatment options that are not evidence-based and/or are known to increase overdose risks.[11]

What are best practices for post-overdose response teams?

BUILDING THE TEAM

- Build an outreach team with professionals who have appropriate training and experience. This may include harm reduction professionals, outreach professionals, certified peer recovery specialists, community healthcare workers and EMS.[1]
- Ensure that all post-overdose outreach staff and support network members have adequate training in harm reduction, trauma-informed care, data management, patient confidentiality and evidence-based strategies for overdose prevention.[1]
- Include people with lived and living experience of substance use and of SUD in the planning, implementation and evaluation of the program.[1,8,13]

INTRODUCING THE TEAM

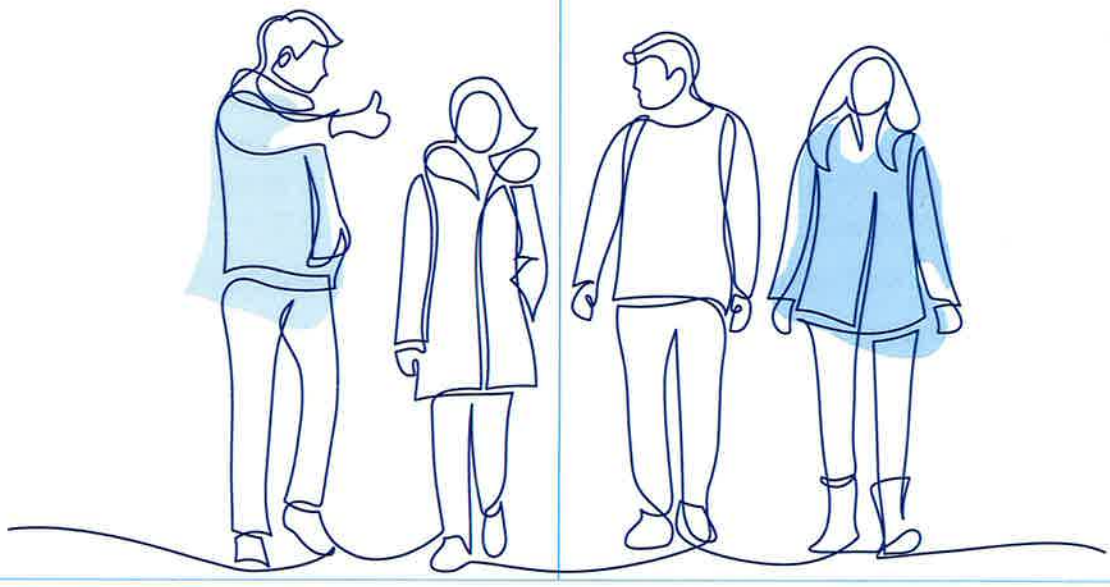
- Connect outreach activities with other post-overdose interventions, such as emergency department-based peer recovery coaching or buprenorphine initiation.[4,5,14]
- Introduce response team staff while the person is still with EMS or in the emergency department being treated for overdose.[5]

SENDING THE TEAM

- Use a clinical screening tool to identify people who have a SUD and are ready for treatment[4] and focus outreach services on these individuals.
- Call ahead. Gaining consent to conduct outreach is associated with better treatment engagement.[6] Unannounced home visits can cause unnecessary stress and worry.[1,9]

EQUIPPING THE TEAM

- Provide linkage to evidence-based treatment (especially MOUD) when treatment is indicated and desired by the person who experienced an overdose.[15]
- Begin medication during the outreach visit.[2,4] Include EMS or other personnel on the team who can administer buprenorphine on site.
- Offer harm reduction services and supplies, like overdose education, naloxone, safer use equipment and fentanyl test strips.[8,16,17]
- Facilitate connections with social services such as shelters, food banks and nutritional assistance. Emerging evidence suggests that these are the most impactful things post-overdose response teams can do.[18,19]



What are some examples of successfully implemented post-overdose response teams?

These and many other model programs are described online at the Brandeis Opioid Resource Connector.

BUNCOMBE COUNTY, N.C. established a post-overdose response team in early 2021. The team follows a community paramedicine model, with teams composed of a community paramedic and a peer support specialist. A core tenant of the program is that team members let people choose the level of help they receive. Since 2022, the team has been authorized to administer buprenorphine immediately following an overdose. If the person is not ready to start receiving MOUD, they can also call the team the next day if they change their mind. The team can continue administering buprenorphine for up to five days, after which they connect the person to local outpatient treatment and resources to address social determinants of health.[20,21]

THE HOUSTON EMERGENCY OPIOID ENGAGEMENT SYSTEM (HEROES), based at the University of Texas Health Science Center, conducts outreach to persons who have experienced an overdose. Eligible participants are identified through the emergency department (where they are screened for SUD and invited to voice their readiness for treatment) or through the local EMS system after naloxone administration for a suspected opioid overdose. Outreach teams consist of a licensed peer recovery coach and a paramedic, who can provide buprenorphine during the visit.[4]

THE KNOX COUNTY HEALTH DEPARTMENT IN TENNESSEE is currently planning its own post-overdose response program designed to provide harm reduction education and increase outreach services to minority populations. In addition to providing healthcare and harm reduction navigation services, Knox County also aims to link survivors with housing in order to support people who use drugs in the early stages of recovery.[22]

ADDITIONAL RESOURCES:

Please visit the Opioid Solutions Center for a curated list of resources, technical assistance opportunities and the sources referenced in this brief.

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