

# Connecting Communities to Substance Use Services: Practical Approaches for First Responders



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## **Abstract**

During their day-to-day work, first responders such as law enforcement officers, firefighters, and emergency medical services (EMS) personnel often encounter people who use drugs (PWUD), including alcohol, opioids, stimulants, and other substances. These encounters provide opportunities to connect people to substance use services and ancillary supports. A growing number of approaches, programs, and other resources are available to help first responders support PWUD so they can receive the assistance they may need.

This guide provides practical, evidenced-based information that first responder agencies, their partners, and communities can use to implement or expand practices and approaches for linking people to substance use services. It presents relevant strategies and public health approaches, resources and program models, and potential challenges and other important factors to consider when implementing approaches to support PWUD.

In addition to first responder agencies and communities, organizations that may benefit from this resource include those seeking to collaborate with first responders, such as substance use treatment providers, local health departments, hospitals, peer and recovery support organizations, harm reduction coalitions, and other community partners.



**MESSAGE FROM THE ASSISTANT SECRETARY  
FOR MENTAL HEALTH AND SUBSTANCE USE,  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

As the Assistant Secretary for Mental Health and Substance Use in the United States Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Connecting Communities to Substance Use Services: Practical Approaches for First Responders*.

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policymakers, and others with the information and tools to incorporate evidence-based practices in their communities or clinical settings. As part of the series, this guide highlights strategies and public health approaches that first responder agencies, their partners, and communities can consider implementing to connect people to substance use services.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, or disability. Each guide recognizes that substance use disorders and mental illnesses are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health providers and community partners must give attention to health equity to improve individual and population health.

I encourage you to use this guide to implement interventions and programs that support individuals living with mental health conditions and/or substance use disorders.

**Miriam E. Delphin-Rittmon, PhD**

Assistant Secretary for Mental Health and Substance Use  
U.S. Department of Health and Human Services

***Behavioral health equity*** is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons; Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

As population demographics continue to shift, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. In all areas, SAMHSA is committed to behavioral health equity.

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<b>Term</b>	<b>Definition</b>
<b>Behavioral Health</b>	The promotion of mental health, resilience, and wellbeing; the treatment of mental health conditions and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. <sup>1</sup>
<b>Community Paramedicine</b>	A community-based model of health care where emergency medical services (EMS) personnel work in expanded roles to provide primary and preventative care in the community. Working outside of their traditional emergency response and transport roles helps improve access to care and may result in more efficient services and lower healthcare costs. <sup>2-3</sup> This service may also be referred to as Mobile Integrated Healthcare (MIH).
<b>Compassion Fatigue</b>	A decreased capacity to care for individuals because of repeated exposures to their suffering and trauma. <sup>4</sup>
<b>Continuum of Care</b>	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to their needs. A continuum of care may include prevention, early intervention, harm reduction, treatment, continuing care, and recovery support. <sup>1</sup>
<b>Crisis</b>	A situation causing significant distress. Crises differ for each individual and may result from adverse changes in life circumstances, such as the loss of a relationship, loved one, or job, or they may represent the worsening of untreated mental health conditions or substance use disorders. Some individuals may be at risk of harming themselves or others, unable to care for themselves or access basic needs like food and shelter, or experience other problems related to substance use and mental health. <sup>5</sup>
<b>Drug Overdose</b>	When a high quantity of a drug or other substance, or combination of drugs or other substances, is used that results in toxicity that can cause harmful symptoms. <sup>6</sup> A drug overdose can be accidental or intentional, as well as fatal or nonfatal.
<b>Evidence-Based</b>	Programs, policies, services, or interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, and that promote individual-level or population-level outcomes.
<b>First Responder</b>	A person with specialized training who, in the course of their professional duties, responds to medical and other emergencies and provides assistance or incident resolution. First responders may include federal, state, and local emergency personnel, agencies, and authorities, such as public safety, EMS, fire, law enforcement, and others with emergency response capabilities, including hospital emergency facilities. In some instances, mobile crisis teams are deployed with, or in place of, traditional first responders. For this guide, first responders include individuals working in law enforcement, fire, and EMS.

<b>Term</b>	<b>Definition</b>
<b>Harm Reduction</b>	A practical approach that incorporates community-driven public health strategies and social supports—including prevention, risk reduction, and health promotion—to reduce the negative consequences associated with substance misuse and empower individuals and their families to live healthy, self-directed, and purpose-filled lives.
<b>Lived Experience</b>	Personal knowledge gained through direct, first-hand involvement. In the context of this report, lived experience refers to individuals who have experienced substance use, misuse, or substance use disorder.
<b>Medications for Opioid Use Disorder (MOUD)</b>	Medications that are Food and Drug Administration (FDA)-approved for the treatment of opioid use disorder (OUD). <sup>7</sup> They are often used in combination with counseling and other behavioral therapies to provide a whole-patient approach to the treatment of OUD. This class of medications includes buprenorphine, methadone, and naltrexone in different formulations.
<b>Motivational Interviewing</b>	A collaborative, person-centered style of communication designed to initiate and/or strengthen motivation to change, and which acknowledges the difficulty of how hard it is to change learned behaviors. It provides a framework for interacting with people experiencing homelessness, mental health conditions and/or substance use disorders, or trauma. <sup>8</sup>
<b>Naloxone</b>	An opioid antagonist medication that rapidly reverses an opioid overdose. <sup>9</sup>
<b>Opioids</b>	A class of drugs that includes legal and illegal substances, such as heroin, fentanyl, and prescription pain relievers like oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and others. <sup>10</sup> Some opioids, like morphine, are naturally derived, while others are synthetic (e.g., methadone) or semi-synthetic (e.g., oxycodone).
<b>Opioid Use Disorder</b>	A type of substance use disorder involving opioid drugs, such as heroin, fentanyl, or prescription opioids (e.g., OxyContin®).
<b>Peers</b>	People with lived experience who have been successful in their recovery process and who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peers help people enter and stay engaged in the recovery process and reduce the likelihood of relapse. Peers are trained as recovery coaches or peer specialists and may include family peer supporters. <sup>5</sup> Peers may be referred to as peer support workers, peer specialists, peer recovery coaches, peer advocates, or peer recovery support specialists.
<b>People Who Use Drugs (PWUD)</b>	People who use or misuse substances like prescription and illicit drugs and alcohol.
<b>Person-Centered</b>	Approaches to language or care that put the person first. Person-centered care means choosing words that recognize and refer to individuals as people and allowing individuals to have control over the care and services they receive, including the amount, duration, scope, and choice of providers. Person-centered approaches are respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual. <sup>11</sup>
<b>Polysubstance Use</b>	The use of more than one drug or substance, taken together or within a short period of time, either intentionally or unintentionally. <sup>12</sup>
<b>Recovery</b>	A process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. <sup>13</sup>

Term	Definition
<b>Recurrence of Symptoms</b>	A phase of recovery where a person's symptoms have returned, and their functioning has decreased. This recurrence may be more commonly referred to as "relapse," "lapse," or "return to use." <sup>5</sup>
<b>Risk Factors</b>	Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other mental health conditions.
<b>Stimulants</b>	A class of drugs that includes legal and illegal drugs, such as cocaine, methamphetamine, and prescription stimulants like dextroamphetamine/amphetamine (Adderall®), methylphenidate (Ritalin®, Concerta®), dextroamphetamine (Dexedrine®), and others. <sup>14-15</sup>
<b>Substance Misuse</b>	The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or those around them. For some substances or individuals, any use would constitute a misuse (e.g., underage drinking, injection drug use). <sup>1</sup>
<b>Substance Use</b>	The use—even one time—of any substance. <sup>1</sup>
<b>Substance Use Disorder</b>	A medical illness caused by repeated misuse of a substance or substances, characterized by impairments in health, social function, and the ability to control one's substance use. Substance use disorders range from mild to severe and from temporary to chronic. Many individuals with substance use disorders experience co-occurring disorders, such as multiple substance use disorders or coexisting mental health conditions.
<b>Substance Use Disorder Treatment</b>	A service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability. <sup>1</sup> May also be referred to as "substance use treatment".
<b>Sustainability</b>	The process of building an adaptive and effective prevention system that achieves and maintains desired, long-term results.
<b>Trauma</b>	An event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or threatening, and has lasting adverse effects on the individual's physical, emotional, social, and/or spiritual well-being. Traumatic events may be experienced by an individual, a generation, or an entire community or culture. <sup>16-17</sup>
<b>Trauma-Informed Approach</b>	A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. <sup>17</sup>



## Chapter 1.

# The Role of First Responders in Connecting People to Substance Use Services

## 1.1 Opportunities for First Responders

A **first responder** is a person with specialized training who, in the course of their professional duties, responds to medical or other emergencies and provides assistance or incident resolution. First responders, including law enforcement officers, firefighters, and emergency medical services (EMS) personnel, often encounter people experiencing emergencies and other challenges related to **substance use or misuse, substance use disorder, or drug overdose**.<sup>18-19</sup> For example, in 2019, about 9 percent of all 911-initiated EMS activations with patient contact may have involved substance use.<sup>20</sup> In 2020, **naloxone** was one of the top 10 medications EMS personnel administered, with over 242,000 **opioid**-related EMS encounters nationwide.<sup>21-22</sup>



### At a Glance...

This chapter presents key concepts, including why first responders are well-positioned to provide resources and support to PWUD, and how they can work with their community to implement strategies and approaches to do so. It also summarizes the substance use services available to PWUD. Use the links below to advance to the section(s) of interest.

#### [Substance Use Services](#)

- Continuum of Care

#### [Shifting to a Community-Wide Approach to Support People Who Use Drugs](#)

- Implementing Collaborative Approaches
- Social Determinants of Health

#### [How to Use This Resource](#)

Given their role in the community, first responders are in a unique position to address the adverse effects of substance use among **people who use drugs (PWUD)**, through practices and approaches that connect them to substance use services and ancillary supports, such as case management, housing, and health care. Without these practices and approaches in place, people who need services often do not receive them. For example, emergency departments may offer some substance use services, like onsite specialty

providers,<sup>a</sup> or facilitate referrals to further care. However, people who survive an overdose related to substance use often decline EMS transport to the emergency department, and therefore may not receive substance use-related care after the emergency. Between March 27, 2022, and March 26, 2023, the yearly percentage of opioid overdose-related transport refusals nationally was just over 21 percent,<sup>23</sup> but may be as high as 42 percent, as this figure varies widely by region.<sup>24-29</sup>

The reasons for declining transport to the hospital include<sup>27, 33</sup>:

- Intolerable withdrawal symptoms
- Fear of law enforcement
- Expectation of inadequate care
- Concern over costs
- Embarrassment
- Stigmatizing treatment

Moreover, a substantial proportion of individuals who do accept transport, or are required to be transported, to the hospital often leave before a healthcare provider sees them. As a result, first responders may be the only professionals or paraprofessionals who interact with PWUD in an emergency,<sup>34</sup> making their actions during this time even more crucial.

First responders can use practices and approaches to connect PWUD to substance use services that leverage partnerships among community providers, including **peers** and outreach workers, treatment providers, and social services agencies.<sup>34-37</sup> It may also be necessary for them to further develop their understanding of substance use and misuse, **trauma-informed approaches**, effective triage methods, and facilitating connections to **substance use disorder treatment** and other resources.<sup>34-37</sup> However, the practices and approaches first responders use may vary greatly depending on the resources of the jurisdiction and the needs of the community.

<sup>a</sup> For simplicity, the term “provider” is used throughout this guide to refer to individuals providing health care, including behavioral health services. The authors recognize that some settings may use other terms, such as clinician or practitioner.



### KEY CONCEPT: People Who Use Drugs

The term “PWUD” includes individuals who use any substances, like prescription and illicit drugs and alcohol, and whose use may include misuse. PWUD may use substances recreationally or habitually, and many, but not all, may meet diagnostic criteria for a substance use disorder. Most first responders are familiar with the term “substance use disorder” and use it to describe PWUD, even if they may not meet the term’s diagnostic criteria.



### TIP: Understand Substance Use in the Context of the Drug Overdose Epidemic

The United States is experiencing a drug overdose epidemic, with the number of drug overdose deaths having quintupled between 1999 and 2020.<sup>30</sup> In 2021, 106,699 drug overdose deaths occurred in the United States, of which 75 percent involved opioids.<sup>31</sup> Opioids have largely driven the drug overdose epidemic, beginning with prescription opioids in the late 1990s, followed by heroin in the mid-2000s, and then fentanyl beginning in the mid-2010s.<sup>30</sup>

However, the number of drug overdose deaths involving **stimulants**, both with and without opioids, is increasing.<sup>32</sup> One reason may be increasing **polysubstance use**, which may be intentional (to experience the effects of the substances combined or to counteract each other) or unintentional (when a substance of choice has been mixed or cut with other substances the user is not aware of).<sup>12</sup>

A brief summary of best practices first responders can implement when responding to opioid overdoses is located in [Appendix B](#).

## Substance Use Services

PWUD, including those who develop a substance use disorder, often have many unmet health and social support needs related to substance use and co-occurring, chronic conditions that increase their risk of morbidity and mortality.<sup>36,38-39</sup> Substance use disorder is a chronic, treatable disease; however, PWUD often experience numerous barriers to receiving services, and most do not get the treatment they need. For example, in 2021, among the 43.7 million people in the United States aged 12 or older who needed substance use treatment, only 4.1 million (9.4 percent) received any treatment in the past year, and even less, 1.1 million (6.9 percent), at a specialty facility.<sup>40</sup>

Barriers to treatment or other substance use services include<sup>41</sup>:

- Stigma
- Lack of perceived need
- Limited availability of treatment providers
- Inability to obtain transportation to services
- Wait time
- Cost
- Other social determinants of health



Substance use services span a **continuum of care** to meet the varying needs of PWUD and may include prevention, early intervention, **harm reduction**, treatment, and **recovery** or other support services.<sup>1,42</sup>

- *Prevention.* Prevention services are **evidence-based** programs, policies, or services that address **risk factors** for substance use. Their goals are to reduce the number of people who initiate substance use and prevent those who have from progressing to misuse.<sup>1</sup> Prevention services may be universal (targeted towards an entire population), selective (aimed at subgroups of a population at an increased risk of substance use), or indicated (aimed at specific individuals who are likely already engaging in substance use).<sup>1</sup>
- *Early intervention.* Early intervention services include screening, detection, brief intervention, and **motivational interviewing** strategies meant to stop a person's problematic substance use or misuse before it becomes chronic, complex, and more difficult to treat.<sup>1</sup> Early intervention services can occur in many different settings, and most include information about the risks of substance use and strategies to quit or reduce use. [Screening, brief intervention, and referral to treatment \(SBIRT\)](#) approaches are a common mechanism for providing early intervention services.<sup>1</sup>



### RESOURCES

More information about [harm reduction](#) is available from the following resources and organizations:

- [National Harm Reduction Technical Assistance Center](#)
- [Syringe Access State Policy Landscape](#)
- [How to Test Your Drugs Using Fentanyl Test Strips \(pamphlet to pass out\)](#)
- [The Substance Abuse and Mental Health Services Administration's \(SAMHSA\) Opioid Overdose Prevention Toolkit](#)
- [SAMHSA's Harm Reduction Framework](#)

- *Harm reduction.* Harm reduction services are a vital part of the continuum of care and serve as a gateway to other healthcare and social services, including specialty treatment, if and when an individual is ready to receive them.<sup>1,42</sup> Harm reduction approaches aim to minimize the negative effects of substance use and misuse. For example, harm reduction strategies to address substance use include drug overdose education, naloxone distribution, access to sterile syringes, and drug-checking services, such as fentanyl test strips. Other harm reduction services include testing and treatment for infectious diseases, peer outreach, case management, and other activities that help prevent harms associated with use and misuse of different substances.
- *Treatment.* Specialty treatment programs encompass comprehensive approaches to care like behavioral therapies, medications, and other support services. They include medically managed withdrawal (also known as withdrawal management programs), inpatient/residential programs, partial hospital/intensive outpatient programs, and outpatient programs.<sup>1</sup> Behavioral therapies effective for the treatment of substance use disorder include individual counseling and psychotherapy, cognitive behavioral therapy, contingency management, and motivational enhancement therapy. Medications can also treat some substance use disorders, but these currently are only FDA-approved for nicotine use disorder, alcohol use disorder, and **opioid use disorder**.
- *Recovery and other supports.* PWUD often need access to additional services to address health and social needs that facilitate recovery. These supports may include social services, like housing and employment assistance, or recovery-specific supports, like recovery coaching and peer support, recovery/case management, recovery housing, and mutual aid and other groups with a support component, such as [SMART Recovery](#).

Substance use services can take place in a variety of settings, for different lengths of time, and may consist of one or multiple services to help reduce or eliminate substance use, depending on the type of misuse or substance use disorder, services available in the community, and the individual's constraints (e.g., insurance coverage or financial resources, work schedule).<sup>1</sup> Less severe substance misuse or substance use disorder may be managed through lower intensity interventions in a general healthcare setting, while more severe substance misuse or substance use disorder may require specialty treatment and post-treatment care. PWUD may also require ancillary services, such as health and social services, which address their overall well-being. Other services may include physical and **behavioral health** care and food, housing, transportation, and employment supports.

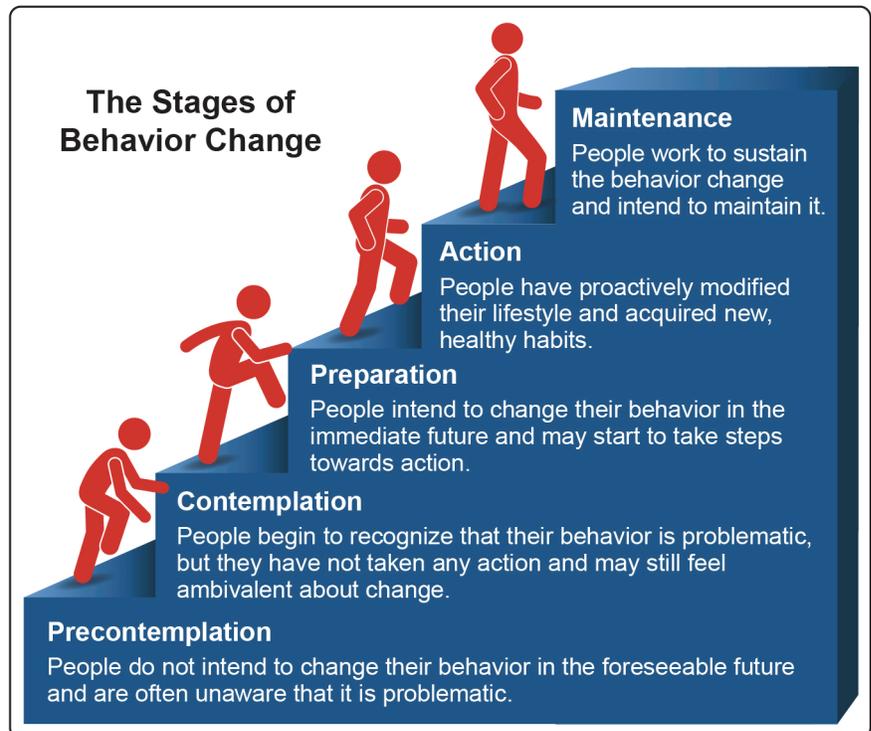
First responders are important community partners along the continuum of care. As professionals and paraprofessionals who often interact with individuals who need substance use services, they play a vital role in connecting PWUD with assistance. While the goal of first responders has historically been to provide immediate assistance and care to individuals in need, they have an opportunity to meet PWUD where they are and help facilitate access to follow-up care. They may, independently or in collaboration with a partner provider or agency:

- Conduct screenings and brief interventions
- Distribute and administer naloxone and other harm reduction supplies
- Provide referrals to substance use and/or social services within the community (e.g., local treatment providers, recovery or peer support, food and housing assistance)
- Transfer an individual's care to the appropriate service



## KEY CONCEPT: Stages of Change

The practices and approaches that first responders use to connect PWUD to substance use services may depend on the resources available and what stage of change the individual is in. Understanding the core [Stages of Behavior Change](#) will drive the conversation with the individual and ultimately determine which services are most appropriate to meet them where they are. For example, the approach with someone in the “pre-contemplation” stage is focused on understanding, compassion, and education, whereas the approach with someone in the “contemplation” stage may include harm reduction, or even treatment and resources.



Adapted from: Boston University School of Public Health. (2022). *The Transtheoretical Model (Stages of Change)*. <https://sphweb.bumc.bu.edu/otl/mph-modules/sb/behavioralchangetheories/behavioralchangetheories6.html>

## 1.2 Shifting to a Community-Wide Approach to Support People Who Use Drugs

PWUD may need access to a variety of community-wide services and supports that span from addressing their immediate needs and emergent care to non-health services, like food or housing. First responders can collaborate with states, tribes, communities, and other jurisdictions and key partners to identify community-wide services and supports available for PWUD. Working together, first responders and their partners can assess community needs and determine what resources are available. They can then identify community-wide approaches and solutions that help improve care coordination for PWUD and that are appropriate and feasible to implement. These may range from foundational practices, such as providing training, to public health approaches and programs that involve collaborating with public health, social service, and criminal justice systems.

Collaborative practices and approaches can be implemented within and across communities and, depending on the approach, may also help address issues beyond substance misuse and substance use disorder, such as mental health conditions, co-occurring disorders, and other chronic health conditions. In addition, these practices and approaches may help ensure individuals receive the care most appropriate for their needs and improve health outcomes. Potential benefits of similar collaborative efforts have included<sup>35</sup>:

- Lower emergency department costs
- Reduced emergency department admissions, resulting in decreased wait times for individuals with medical emergencies not related to substance use because PWUD are diverted to more appropriate care
- Decreased burden on other systems less equipped to address problems or concerns related to substance use or misuse

- Reduced number of arrests and jail admissions among individuals with mental health conditions and substance use disorders, as well as associated criminal justice costs
- Improved access to quality care for PWUD

Ensuring that PWUD receive the care most appropriate for their needs may also help eliminate many sociodemographic and structural barriers these individuals experience, which result in the service gaps that contribute to their low engagement in health care.<sup>36</sup> These barriers and service gaps create health inequities<sup>43</sup> and may make some subpopulations of PWUD more vulnerable to adverse health outcomes. For example:

- *Racial and ethnic minorities.* Members of racial and ethnic minority groups are more likely to report negative experiences with the healthcare system because of discrimination and racial bias.<sup>44-45</sup> They are less likely to receive drug overdose prevention and substance use services compared with White people.<sup>46-49</sup> Not addressing prevention among communities of color is concerning given they, especially Black and American Indian and Alaska Native communities, have experienced disproportionate increases in drug overdose death rates in recent years.<sup>46, 50</sup>
- *People who inject drugs.* The consequences of health disparities and stigma can be especially dire for people who inject drugs, as they are at greater risk for drug overdose, HIV, hepatitis C, soft tissue infections, endocarditis, and other substance use-related complications.<sup>51-56</sup>
- *Pregnant women.* Rates of opioid use and related diagnoses are increasing among pregnant women, as have rates of neonatal abstinence syndrome.<sup>57-58</sup> Opioid use during pregnancy is associated with poor health outcomes for both the parent and child, including maternal death and stillbirth.<sup>58</sup> Further, Black women are particularly vulnerable to experiencing social bias and punitive legal system approaches because of substance use while pregnant.<sup>59</sup>



Adapted from: The National Council for Mental Wellbeing. (2021). *An overview of deflection and pre-arrest diversion to prevent opioid overdose.* [https://www.thenationalcouncil.org/wp-content/uploads/2022/02/NC\\_1\\_DPAD\\_Overview\\_Pre-ArrestDiversion.pdf](https://www.thenationalcouncil.org/wp-content/uploads/2022/02/NC_1_DPAD_Overview_Pre-ArrestDiversion.pdf)





## KEY CONCEPT: Social Determinants of Health

Social determinants of health are the conditions and circumstances that impact one's health and may influence substance use. Grouped into five key domains, these factors can have a greater influence on health than health care or lifestyle.<sup>60</sup> The five key domains are<sup>61</sup>:

- Economic stability
- Education access and quality
- Healthcare access and quality
- Neighborhood and built environment (including housing and transportation)
- Social and community context

Structural racism is a concept related to social determinants of health that refers to how societies promote racial discrimination through systems that reinforce discriminatory beliefs.<sup>62</sup> Structural racism is directly related to health inequity, and is a driving force of the social determinants of health.<sup>63</sup>

## 1.3 How to Use This Resource

First responders can take advantage of the critical few minutes they interact with PWUD as an opportunity to bring awareness, support, and resources to someone who may not know where to turn for help. This guide outlines the steps first responders can take to develop strategies, approaches, and partnerships that help connect PWUD to substance use services. Each chapter presents context, guidance, and resources that support states, tribes, communities, systems, and first responders in implementing approaches and strategies that facilitate access to substance use services for PWUD.

The approaches and strategies outlined in this guide are offered as suggestions to improve the safety and care of PWUD and reduce challenges first responders may face when working with this population. There may be barriers when implementing some of these suggestions, such as funding challenges many first responder agencies face, especially EMS agencies as most jurisdictions do not consider them essential services. As of December 2022, at least 13 states have designated EMS as essential.<sup>64</sup>

Ongoing public health crises, like the drug overdose epidemic, may compound funding issues. For example, if EMS personnel respond to a service call for someone experiencing a drug overdose and that individual refuses transport to the emergency department, the agency is often not reimbursed.<sup>64-65</sup> Over time, this can become costly for agencies. By applying the strategies and approaches in this guide, first responders may be able to reduce the cost burden associated with non-reimbursable engagements by ensuring PWUD receive naloxone and other harm reduction services and are referred to substance use services, when possible. This may reduce the likelihood of repeat drug overdoses and, consequently, the number of non-reimbursable responses. Similarly, these strategies and approaches may help reduce criminal justice-related costs for law enforcement.

First responder agencies do not typically have funds to support PWUD alone, and this guide emphasizes the importance of collaboration across community partners. Individuals in first responder agencies who committed to making a difference in their communities developed many of the strategies in this guide. They leveraged innovative solutions, relied on partnerships and volunteers, and reduced impact on their own operating budgets while expanding access to available resources. These collaborative efforts may also allow first responder agencies to apply for funding for which they otherwise may not be eligible. Further, implementing these strategies and approaches may help reinforce the positive impacts first responders have in their communities, especially in areas where their services are not deemed essential or where they have been negatively viewed.



## Chapter 2.

# Foundational Skills and Practices to Support People Who Use Drugs

## 2.1. Addressing Community Needs Through Foundational Skills and Practices

First responders are most likely to interact with people who use drugs (PWUD) in response to a service call; however, there may be other contexts where they will encounter this population. For example, PWUD may initiate interactions in a non-emergency situation if they are seeking services or support for their substance use.<sup>18</sup> There are several foundational skills and practices first responders can implement to ensure their encounters with PWUD are positive, regardless of the setting or context; this could include training to better understand the causes of substance use and familiarity with what relevant community resources are available for PWUD.<sup>34</sup>



### At a Glance...

This chapter provides guidance and resources first responders can use to best address the needs of PWUD, beginning with education and training and spanning to capacity building activities that help create and formalize partnerships. Use the links below to advance to the section(s) of interest.

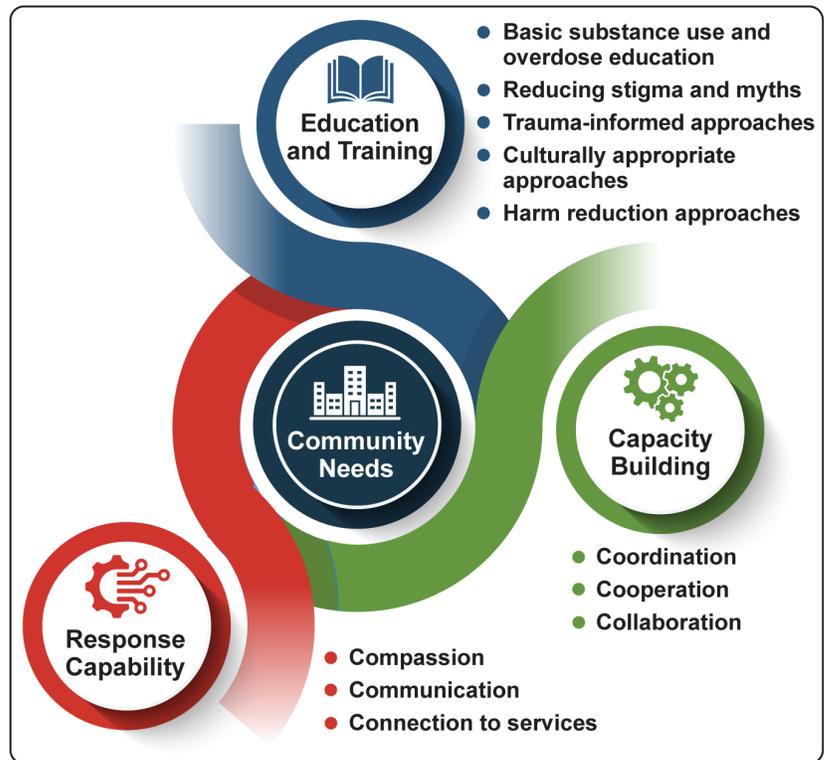
[Education and Training](#)

[Response Capability](#)

[Capacity Building](#)

Developing these skills and practices can be facilitated by developing partnerships with other community agencies or organizations that work with PWUD to support and supplement first responders' efforts. These partnerships can help first responders develop the capacity to provide more direct support, or even services, to this population. The skills and practices suggested in this chapter can be implemented as a singular effort, or in combination with more comprehensive public health approaches that address the needs of PWUD.

## 2.2 Education and Training



Interactions between first responders and PWUD, when initiated by a service call, offer a brief opportunity to provide assessments and resources.<sup>34</sup> However, first responders may lack the basic training and resources necessary for providing this support to PWUD.<sup>66-68</sup> Training is, therefore, a vital component of ensuring these interactions are as beneficial as possible to the person in need. First responders may benefit, at a minimum, from training in the following areas:

- *Basic substance use and drug overdose education.* Understanding the key concepts of substance use and recognizing that substance use disorder is a chronic disease caused by a combination of genetic and environmental factors that change how the brain works is important for ensuring PWUD receive appropriate services. Basic substance use education helps people understand that substance misuse and substance use disorders are not moral failings, and that people can recover. This type of training includes information about treatment, **recurrence of symptoms**, and recovery.<sup>34</sup> First responders may also benefit from training on how to recognize and respond to different types of drug overdoses, including overdose from opioid, stimulant, and polysubstance use, and symptoms of withdrawal from substances.



### TIP: Support Self-Care for First Responders

The role of the first responder is inherently stressful, with many systemic challenges facing the workforce. It can be discouraging to repeatedly respond to service calls from individuals with chronic conditions, including substance use disorder, and not have the resources to help. While this is a normal emotion in response to the first responder's work environment, it may result in a lack of empathy, burnout, **compassion fatigue**, and the worsening of one's mental health. First responders who know how to care for their own mental health and prioritize wellness and self-care will be better able to manage the stress associated with their work.



## RESOURCES

There are many resources available to address compassion fatigue, including tip sheets, toolkits, and mobile apps. Some of these include:

[The First Responder Toolkit App](#)

[First Responder Compassion Fatigue Tip Sheet](#)

[Emergency Responders: Tips for Taking Care of Yourself](#)

[Stress, Burnout, and Trauma Through the Eyes of First Responders and Health Care Workers](#)

[Compassion Fatigue Awareness Project](#)

[CrewCare Mobile App](#)

[Service to Self Training Course](#)

[Shield of Resilience Training Course](#)

[Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies](#)

- *Reducing stigma and myths.* PWUD often experience stigma that can be dehumanizing and discourage them from seeking care. One key aspect of reducing stigma is changing the language used to refer to PWUD. Stigma may also result from myths around substance use. Education should include how to communicate using person-first language, which focuses on the person and not the disease, and dispelling myths around substance use.<sup>34</sup>
- *Trauma-informed approaches.* PWUD may have had negative experiences with first responders and other medical or treatment providers in the past and may also have a history of experiencing **trauma**. First responders should be trained to recognize that trauma is common, assume that an individual has experienced trauma when initiating an interaction, and interact with individuals in a way that is [trauma-informed](#). Such an interaction will help reduce the likelihood of an adverse physical or emotional reaction based on a past traumatic experience. In addition, first responders should be able to recognize signs of fear and distress as a potentially traumatic response, and not assume it is because an individual has done something wrong. The response should be de-escalating and non-threatening, not accusatory.<sup>34,67</sup>
- *Culturally appropriate approaches.* Delivering culturally appropriate services improves care quality and may positively impact how and when individuals seek care.<sup>69-70</sup> Cultural competence goes beyond understanding racial and ethnic differences and extends to minority or disadvantaged populations, including individuals with disabilities, those from different socioeconomic groups, and sexual and gender minorities, such as those who identify as lesbian, gay, bisexual, transgender, queer, questioning, or intersex (LGBTQI+).<sup>71-72</sup> These approaches help improve health outcomes for marginalized groups and [advance health equity](#). First responders should be familiar with how to tailor their response in a way that respects cultural and linguistic differences and aligns with an individual's beliefs, attitudes, values, and behaviors.
- *Harm reduction approaches.* As described in [Chapter 1](#), harm reduction approaches focus on evidence-based strategies that reduce the negative consequences of substance use. First responders should be educated on the concept of harm reduction, the benefits of these strategies for PWUD and the responders who engage with them, and local harm reduction services and resources they can share with PWUD, such as where to obtain naloxone, fentanyl test strips, and safe syringes.<sup>34</sup>

Several training and educational resources are available on these and other topics through organizations and websites like [HealthKnowledge](#), which offers a variety of courses in its “[Substance Use Disorder Basics](#)” section, including “Understanding Substance Use Disorders,” “Addressing Stigma and Substance Use Disorders,” and other topics, like cultural humility and competence and substance use disorders in special populations. The Substance Abuse and Mental Health Services Administration’s (SAMHSA) [Technology Transfer Centers \(TTCs\)](#) also have several training and educational resources on these topics; a more detailed list of training and educational resources can be found in [Appendix C](#).

## 2.3 Response Capability

First responders’ interactions with PWUD, regardless of how short, should be as positive as possible, keeping in mind that the goal is not to treat an individual, but to move them closer to seeking and obtaining help.<sup>34</sup> First responders should exhibit patience during these interactions and realize that the individual may only be receptive to receiving resources, not being transported to a treatment program or engaging in other activities or services.<sup>34</sup> Interactions should be centered on the following principles:

- *Compassion.* First responders should treat PWUD with the same compassion, understanding, and respect that they would when responding to individuals with other chronic conditions.<sup>34,70,73</sup> Their approach should be empathetic, **person-centered**, trauma-informed, and culturally appropriate. Person-first language should always be used with PWUD. [Appendix D](#) contains a reference chart with appropriate person-first language to use when talking to, or about, substance use and PWUD.
- *Communication.* First responders can approach individuals in a non-threatening manner, state their intentions plainly and calmly, ask if it is alright to speak with them about their substance use, and respect their wishes if they do not want to. To develop rapport with the individual, they can speak to them at eye-level, ask permission to enter their personal space, and use their name. It is important to use principles of [motivational interviewing](#) when communicating with the individual, being mindful of the language used.<sup>34</sup> First responders should also communicate with family members or others on the scene when possible; this interaction may include providing them with naloxone and instructions on how to use it, or referring them to agencies that provide support services.<sup>34,74</sup> [Appendix E](#) includes resources for dialogue that first responders can use to guide their interactions with PWUD, as well as friends, family, and others close to the individual.
- *Connections to services.* First responders can offer to connect PWUD to substance use treatment and other services. Depending on an individual’s level of readiness, this assistance may only entail harm reduction resources, like leaving naloxone and a brochure with additional information; for others, it may require arranging transportation to a treatment facility or providing a referral to community providers.<sup>34</sup> Understanding the resources available in the community, such as treatment centers and other providers, are key to a first responder’s ability to connect PWUD to services.<sup>75-77</sup> [Appendix F](#) contains tools and information on identifying resources and developing resource lists. Motivational interviewing and screening, brief intervention, and referral to treatment (SBIRT) are two methods first responders can use to determine the appropriate services the individual needs and identify how the individual can access them.<sup>34,78</sup> However, these approaches may not always be possible depending on the time and resource constraints on first responders.<sup>79-80</sup> Instead, first responders may partner with community organizations and programs, including behavioral health providers and peers, who can perform more formal assessments for service needs and reduce pressure on the healthcare system, including emergency departments.<sup>81</sup>

Over time, first responders may have multiple interactions with the same PWUD, which affords the opportunity to establish rapport with them and build trust. Providing trusted support can facilitate a person’s transition to seeking care, adherence to treatments, and achievement of positive health outcomes.<sup>82</sup>



## KEY CONCEPT: Similarities Between PWUD and Other Individuals With Chronic Conditions

PWUD who are experiencing a **crisis** should be treated no differently than individuals with other chronic conditions, though this does not always happen.<sup>34</sup> For example, a health-related emergency for a hypoglycemic individual may result in a loss of consciousness from low blood sugar. This individual is usually treated with a medication—dextrose—to revive them. Once the individual is awake, they may be transported to the emergency department, or they may refuse transport. First responders will offer resources to individuals who refuse transport, such as suggesting they modify their diet to maintain their sugar or follow-up with their doctor to ensure their insulin dosing does not need to be adjusted.

Similarly, PWUD may experience an emergency where they lose consciousness because they have ingested too much of a substance. If that substance is an opioid, the individual is treated with a medication—naloxone. Once the individual is awake, they may also be transported to the emergency department, or they may refuse transport. However, oftentimes, PWUD are not offered additional resources or follow-up care options. First responders may want to implement approaches for connecting PWUD to resources that improve their health and well-being, just as they would for individuals with other health emergencies.<sup>34,83</sup>



## RESOURCES

- The [UCLA Center for Health Policy Research](#) has a guide available to help with resource and asset mapping.
- The National Institute on Drug Abuse has a [reference chart](#) available to guide the selection of screening and assessment tools first responders can use to identify substance use.
- A more detailed list of [Screening and Assessment Tools for Substance Use Disorder](#) is available from SAMHSA and the Administration for Children and Families National Center on Substance Abuse and Child Welfare.
- The Commonwealth of Massachusetts has developed [A Step-By-Step Guide for Screening and Intervening for Unhealthy Alcohol and Other Drug Use](#) that contains screening and SBIRT approaches, as well as a brief motivational interviewing script first responders can use.
- SAMHSA has a brief advisory on [Using Motivational Interviewing in Substance Use Disorder Treatment](#) that covers the fundamentals of motivational interviewing and contains links to several other motivational interviewing resources.
- Several educational opportunities on motivational interviewing are available for first responders, like this six-hour, interactive course on [Motivational Interviewing for Paramedics](#), designed to introduce participants to the core concepts of motivational interviewing, and this 12-hour course on [Motivational Interviewing for Law Enforcement](#), which presents assessment and communication strategies to use with PWUD.
- The National Center on Advancing Person-Centered Practices and Systems has many [resources](#) available on person-centered practices and care that span several topic areas and disciplines.
- SAMHSA's [Practical Guide for Implementing a Trauma-Informed Approach](#) updates and expands on SAMHSA's [Concept of Trauma and Guidance for a Trauma-Informed Approach](#) manual by providing implementation strategies across multiple domains based on the original publication.

## 2.4 Capacity Building

Communities can work to build capacity (skills, knowledge, systems, and structures)<sup>85</sup> and expand resources that support first responders in assisting PWUD. Providing support for PWUD is an ongoing process that involves different types of services and providers to meet a range of needs.<sup>36,86</sup> Support for PWUD is enhanced when first responders build capacity by developing strong, collaborative, multi-disciplinary alliances with other community partners to ensure PWUD receive the resources and services they need.<sup>36,75,86</sup> A crucial first step in capacity building is conducting needs assessments to identify, define, and understand the problem and existing strengths and gaps. A needs assessment can help identify the following<sup>87-88</sup>:

- Current conditions, types of substance use problems, and available, as well as needed, services or resources
- Strengths of a program and the challenges faced in meeting the needs of those served
- Available resources focused on substance use, such as community programs and coalitions, that can be integrated into practices and approaches to support PWUD, including overlapping or duplicative efforts
- Opportunities to expand and combine resources

A needs assessment should be objective and include input from key community partners, including people with **lived experience**.<sup>89-90</sup> The key steps for conducting needs assessments include<sup>87</sup>:

1. Define the goals for the assessment
2. Define the purpose of the assessment
3. Identify the target populations for the assessment of needs and services
4. Select or develop an assessment tool and determine how data will be collected and used
5. Determine the timeline for the assessment process
6. Determine the strategic use of the findings

Periodic needs assessments will ensure communities implement programming responsive to current circumstances, adjusting as problems evolve.<sup>91</sup> Once a community completes a needs assessment, they can use the information to develop and strengthen strategic partnerships to improve resource allocations to meet community needs<sup>88</sup> and contribute to expanded services for PWUD.

Key steps to capacity building and developing successful partnerships include<sup>92-93</sup>:

- *Coordination.* A needs assessment will help communities understand what each agency and organization is doing and how these activities connect. This will allow partners to define available resources across organizations and exchange information and materials.<sup>94</sup>
- *Cooperation.* Once the community has coordinated their activities and resources, they can work together to develop specific roles and responsibilities for each agency and organization. They can formalize their partnerships with a memorandum of agreement (MOA), like [this one from the Bureau of Justice Assistance](#), which outlines the responsibilities and expectations of each partner.



### KEY CONCEPT: Equity

When working to build capacity, recognize that some communities and populations have been historically disenfranchised, limiting their opportunity to experience optimal health, safety, and well-being. Advancing health equity, defined as the state in which everyone has a fair and just opportunity to attain their highest level of health<sup>84</sup> and social justice, requires partnerships and collaborative action.

- *Collaboration.* First responders and their partners can then identify common goals, as well as strategies, projects, and other opportunities to work together on to achieve their goals and build community capacity.

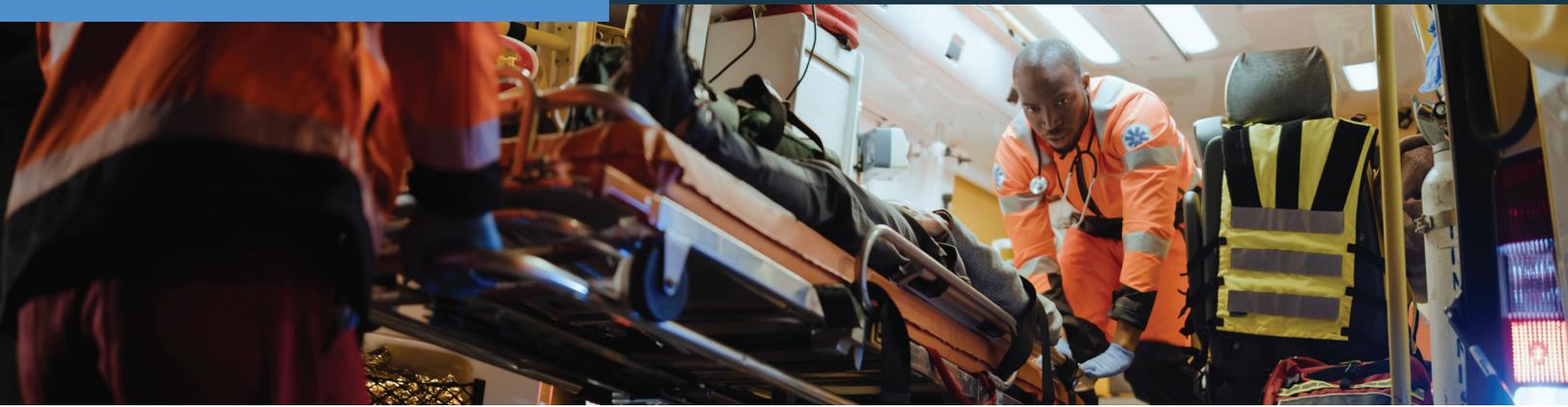
### Building Capacity Through Community Partnerships

PUBLIC SAFETY OFFICIALS	PUBLIC HEALTH AGENCIES	SOCIAL SERVICES AGENCIES	OTHER RELEVANT COMMUNITY PARTNERS
<ul style="list-style-type: none"> <li>• Court systems</li> <li>• Parole systems</li> <li>• Corrections</li> <li>• Prosecutors</li> <li>• Emergency services (fire, police, EMS)</li> </ul>	<ul style="list-style-type: none"> <li>• State and local health departments</li> <li>• Behavioral health treatment</li> <li>• Hospitals</li> <li>• Other healthcare providers</li> <li>• Harm reduction agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Child and family welfare</li> <li>• Housing</li> <li>• Transportation</li> <li>• Education</li> </ul>	<ul style="list-style-type: none"> <li>• Policy experts</li> <li>• Parents</li> <li>• Educators</li> <li>• Funders</li> <li>• Faith communities</li> <li>• Community-based organizations</li> <li>• People with lived experience</li> <li>• Advocacy groups</li> <li>• Recovery/peer support services</li> </ul>

Adapted from: The National Council for Mental Wellbeing. (2021). *An overview of deflection and pre-arrest diversion to prevent opioid overdose.* [https://www.thenationalcouncil.org/wp-content/uploads/2022/02/NC\\_1\\_DPAD\\_Overview\\_Pre-ArrestDiversion.pdf](https://www.thenationalcouncil.org/wp-content/uploads/2022/02/NC_1_DPAD_Overview_Pre-ArrestDiversion.pdf)

## RESOURCES

- [Recovery Corps](#) trains AmeriCorps volunteers as recovery navigators to offer peer support, mentoring, and other services. They also train Recovery Project Coordinators to help build capacity by supporting program development, training, and other areas.
- SAMHSA and ACF fund the [National Center on Substance Abuse and Child Welfare](#), which has several resources for building collaborative capacity to serve families affected by substance use. These resources include both policy and practice initiatives and state and local examples.
- The National Association of Counties developed [The Principles: A Quick Guide to Conducting a Needs Assessment](#) specifically for jurisdictions to identify interventions that prevent overdose.



## Chapter 3.

# Public Health Approaches First Responders Can Use to Support People Who Use Drugs

## 3.1 Development and Implementation of Public Health Approaches

Several public health approaches that first responders currently use build on the fundamental practices discussed in [Chapter 2](#) of this guide and help connect people who use drugs (PWUD) to the services they need. These approaches can facilitate engagement with this population in different ways. Comprehensive approaches will integrate first responders with community partners, such as behavioral health providers or peers, to help assess the needs of PWUD and connect them with substance use services. Choosing the optimal approach depends on several factors, including the needs of the target population and the capacity of the organizations involved.

This chapter presents a range of public health approaches that first responders can implement, independently or with partners, to support PWUD, as well as examples of approaches that communities have implemented in different regions of the United States.



### At a Glance...

This chapter summarizes four public health approaches first responders can use to support PWUD and provides examples of programs using these approaches throughout the country. Use the links below to advance to the section(s) of interest.

#### [Referral](#)

- Self-Referral
- First Responder Referral

#### [Outreach Approaches](#)

- Active Outreach
- Post-Overdose Outreach

#### [Community Paramedicine Approaches](#)

#### [Diversion Approaches](#)

Common elements and features of public health approaches include forming alliances among different community partners, integration of public health and public safety practices, and facilitating access to a range of substance use services. These approaches are often implemented in a similar way by law enforcement, fire, and emergency medical services (EMS), but may vary slightly. For example, some public health approaches may require first responders with specific credentials, training, or authority to perform certain practices (e.g., paramedics are permitted to administer **medications for opioid use disorder (MOUD)**, while emergency medical technicians, who are commonly referred to as EMTs, are not).

When selecting an approach to support PWUD, first responders and their collaborators should answer the following questions:

- Who is leading the charge?
- What would benefit the community?
- Where are the service needs and gaps in the community?

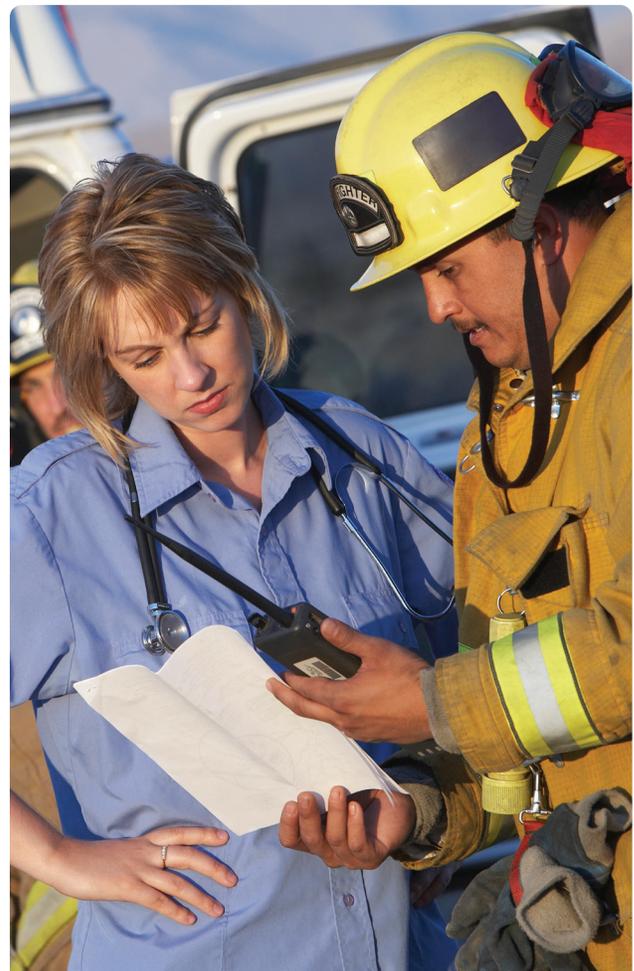
Providing person-centered care that connects PWUD with the most appropriate services in the most appropriate settings should be a key consideration when selecting approaches to serve this population. These should rely heavily on community partnerships, consider composition of response teams (such as the inclusion of people with lived experience), and emphasize the importance of data collection and data-driven decision-making. In addition, agency or organizational leadership buy-in is key to facilitating implementation.<sup>75</sup>

The [Brandeis Opioid Resource Connector](#) is a collection of programs, tools, and resources to help communities select, develop, and implement approaches and interventions for working with PWUD. This resource includes interventions beyond those presented in this guide.



## KEY CONCEPT: Deflection

Many of the public health approaches presented in this chapter have evolved from deflection approaches that were developed by law enforcement and have been expanded to encompass all first responder types. Deflection approaches, also known as deflection pathways, incorporate public health approaches that refer, or deflect, an individual away from the criminal justice system and towards mental health, substance use, and social services. Law enforcement recognizes [six deflection pathways](#),<sup>92,95</sup> which may also be applied to other situations first responders may encounter, such as individuals experiencing psychotic episodes.





## TIP: Tailor Approaches as Needs Evolve

Illicit drugs are often mixed with other substances, known as adulterants, which may be poorer quality and amplify the effects of the drug at a cheaper cost. Adulterants like xylazine and illicit benzodiazepines are increasingly appearing in the illicit drug supply, and drug overdoses from these substances, particularly in combination with fentanyl and other opioids, can be fatal.<sup>96-99</sup> People with repeated exposure to these drug combinations may develop dependence to both the opioid and the adulterant. As a result, they may struggle with treatment for their opioid use if their withdrawal from the other substance is unaddressed. Exposure to adulterants can also have other adverse health impacts. For example, xylazine has been linked to severe, necrotic skin ulcerations that require wound care, especially among people who inject drugs.<sup>100</sup>

PWUD, as well as first responders, may not be aware of the presence of adulterants in the illicit drug supply. This unawareness creates new challenges for first responders, as the actions needed to stabilize an individual will depend on the substance or combination of substances used. Naloxone can successfully reverse the effects of opioids but is not effective for other drugs.<sup>99-100</sup> If the substance or combination of substances is unknown, first responders may not have the information needed to identify and successfully manage a drug overdose.

As the illicit drug supply continues to change, it is essential that first responders regularly assess their approaches to caring for PWUD, so that they continue to meet the evolving needs of the community. First responders can work closely with their state's Drug Monitoring Initiative or other regional and local drug task forces to remain aware of evolving synthetic drugs and other changing patterns related to substance use and misuse in their region.<sup>101-103</sup>

## 3.2 Public Health Approaches and Examples of Programs

The approaches presented in this section build on the foundational practices discussed in [Chapter 2](#). Although these approaches emerged largely in response to the opioid epidemic, many can be implemented and tailored to other substance use disorders or substance use and misuse more broadly. This section includes:

- A summary of each public health approach
- The first responder agency that can lead the approach (denoted by symbols for EMS , fire , and law enforcement )
- Examples of programs that have implemented the approach in many different areas of the country (outcomes of these approaches are also included if research studies are available)

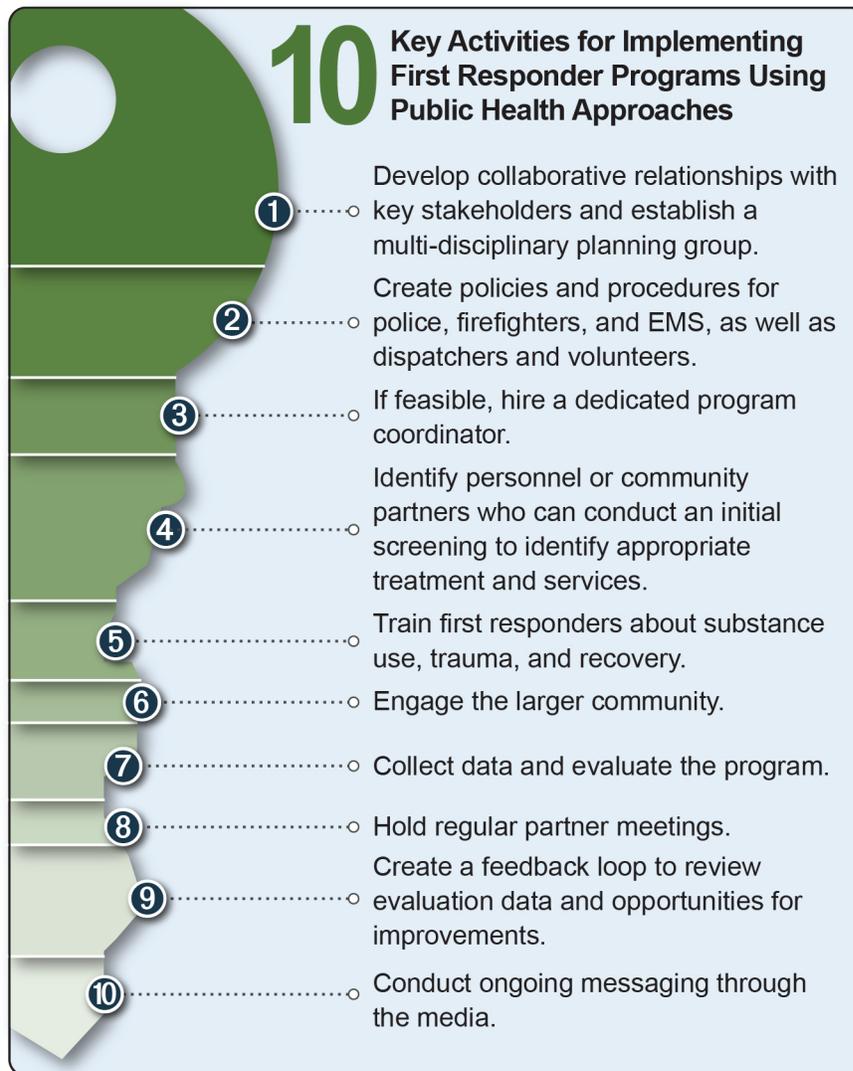
It is important to note that many program examples do not strictly use one approach. Instead, programming often blends many, or even all, aspects of the approaches presented and incorporates multidisciplinary partnerships.

### Referral Approaches

Referral approaches can be initiated by first responders or PWUD (in which case, they are referred to as self-referral). First responder referral approaches occur when a first responder engages an individual about their desire to receive substance use services. These referrals typically occur during normal activities, such as law enforcement patrols or service calls.

First responder referrals often go hand-in-hand with self-referral approaches. Self-referral approaches are when an individual voluntarily initiates contact with a first responder agency for a referral to substance use services or treatment programs.<sup>18</sup> (In the event the first responder type is law enforcement, this contact can be initiated without fear of arrest). Self-referral approaches tend to be mostly law enforcement-led initiatives, but they can be implemented by any first responder agency, and most operate the same way, regardless of who is leading the initiative.

Self-referral approaches are modeled after the [ANGEL Program](#) that was developed in Gloucester, Massachusetts. During the first year of the Gloucester ANGEL Program, 376 different people sought assistance a total of 429 times. In 394 instances, where the person was eligible for direct placement, it was offered, and 374 (or almost 95 percent) of them entered a program—a rate greater than similar hospital-based



Source: Bureau of Justice Assistance (BJA) Comprehensive Opioid Stimulant and Substance Use Program. (n.d.). *Self-Referral Pathway*. [https://www.cossapresources.org/Content/Documents/Articles/CHJ\\_Pathways\\_to\\_Diversion\\_Self-Referral.pdf](https://www.cossapresources.org/Content/Documents/Articles/CHJ_Pathways_to_Diversion_Self-Referral.pdf)



initiatives.<sup>104</sup> Since its creation, the ANGEL Program has grown to provide even more services through the agency's [Community Impact Unit](#), and has encouraged implementation of similar programs throughout the country. These other programs include varying models of service delivery, such as [Hope Not Handcuffs](#) in New York and Michigan, where individuals can approach any participating law enforcement agency or community partner, who will guide the individual into a proper treatment program. There are many such programs, which are highlighted in the table below.

Examples of Self-Referral Approaches			
Program Name	Location	Lead Agency	Description
<a href="#">ANGEL</a>	Gloucester, MA	Law Enforcement	One of the first programs of its type in the country and the model for several other similar initiatives, the <a href="#">Gloucester Police Department's ANGEL program</a> gained recognition for announcing, "Any person who enters the police station and requests help with their addiction to opiates will be immediately screened into the ANGEL Program. If a person who has requested help with their addiction is in possession of drugs or their drug equipment (needles, etc.), they will not be charged. Any officers having contact with anyone entering the Gloucester Police Department and requesting help with their addiction will be professional, compassionate, and understanding at all times. The officer will immediately notify the Watch Commander that a potential Angel intake is requesting help with their addiction."
<a href="#">A Way Out</a>	McHenry County, IL	Law Enforcement	A Way Out assists anyone in the county seeking recovery. Individuals can walk into the station 24/7 and will meet with a representative to complete the required screening forms. If individuals do not require immediate medical attention, the representative will transport them to a local hospital for a treatment assessment. Individuals who require immediate medical attention will be transported to the nearest hospital, and once stabilized, will be screened.
<a href="#">Gateway Program</a>	Ashland, OR	Law Enforcement	Individuals who enter Ashland's station seeking assistance with their substance use are provided with a priority assessment voucher. They can present this voucher at a local recovery center, where they will be evaluated and placed in an appropriate treatment program.
<a href="#">Safe Passage</a>	Lee and Whiteside Counties, IL	Law Enforcement	Safe Passage permits individuals to walk into the police station, where an officer conducts an intake process. If the officer determines the individual is eligible, the officer contacts a treatment provider with whom they have a pre-arrangement to conduct a telephone interview and determine treatment placement. Trained volunteers are available to transport individuals to treatment programs, if necessary.
<a href="#">Safe Stations</a>	Anne Arundel County, MD	Fire and Law Enforcement	The Safe Stations program allows individuals to walk into the county's fire or law enforcement stations day or night to receive help with their substance use. Individuals receive a medical evaluation. If there are immediate medical needs, they will be brought to a medical facility. Otherwise, the individual will work with Crisis Response to determine the best treatment options.

Under a self-referral approach, most agencies will follow an established protocol, such as the completion of intake forms and initial assessments to determine eligibility, although requirements vary by program.<sup>18</sup> Initial interaction with individuals may be with first responders themselves or with others from the agency, like a volunteer or program coordinator; in some instances, agencies may collaborate with behavioral health clinics who will provide staff to work with individuals.<sup>18</sup> First responders and collaborators identify appropriate treatment programs and placement, and may provide transportation or other support to individuals.

Self-referral programs are generally straightforward to implement, acceptable to participants, and have demonstrated effectiveness in facilitating access to substance use treatment.<sup>76</sup> Early research on programs using the self-referral approach have suggested that this practice is associated with decreases in the number of drug overdoses; decreases in crime rates, the number of arrests, and associated criminal justice costs; improved community relationships and collaboration; and reduced stigma among first responders.<sup>18,105</sup> However, the success of these programs often depends on developing community partnerships and ensuring the availability of long-term treatment services and recovery supports.<sup>76,106</sup>

More information about the self-referral approach, as well as case studies of programs that have been implemented throughout the United States, can be found in the Bureau of Justice Assistance's (BJA) Comprehensive Opioid, Stimulant, and Substance Use Program's<sup>b</sup> (COSSUP) Law Enforcement and First Responder Diversion Pathways to Diversion Case Study Series on the [Self-Referral Pathway](#).

## Outreach Approaches

Outreach approaches are initiated by first responders or their partners. These approaches are not typically conducted during a service call. Instead, first responders establish contact with PWUD, and then a multidisciplinary team, which can include first responders, behavioral health providers, peers, and others, educate PWUD about available resources or provide them with naloxone or other harm reduction supplies. There are two broad categories of outreach approaches:

- *Active outreach.* When conducting active outreach, first responders seek out individuals to refer to substance use services or treatment. Active outreach can be 1) targeted, where first responders identify specific individuals based on law enforcement reports, naloxone administration, or referral from community members; or 2) broad, where first responders will conduct outreach activities in known areas or communities with high rates of substance use. Active outreach approaches are similar to first responder referral approaches, except that the first responder is specifically assigned to conduct outreach, as opposed to referrals that result during their traditional first responder assignments.
- *Post-overdose outreach.* Post-overdose outreach is a targeted approach wherein first responders conduct outreach to people who have survived a recent drug overdose and offer referrals to substance use services or treatment. Post-overdose outreach approaches may be immediate (e.g., at the scene of an overdose) or within a certain timeframe after a drug overdose and/or naloxone administration (typically one to three days<sup>107</sup>). [Best practice guidelines](#) for post-overdose outreach programs are available for organizations that develop, operate, or fund such programs. Several different approaches to post-overdose outreach have been adopted, including post-overdose response teams (PORT) and naloxone leave-behind programs:

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<sup>b</sup> Formerly called the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP), and may be referred to as such on some documents and resources.

- » [Post-overdose response teams \(PORTs\)](#). Post-overdose response teams visit people who have survived a recent drug overdose and direct them to substance use and other services or supports to improve their health and well-being. These services may include substance use treatment, harm reduction services, healthcare providers, and social services. The [Post-Overdose Response Team \(PORT\) Toolkit](#) provides guidance on creating a PORT program, including assessment, design, implementation, and evaluation. PORTs are also referred to as [Quick Response Teams \(QRTs\)](#), [Rapid Response Teams \(RRTs\)](#), or [Post-Overdose Support Teams \(POSTs\)](#).
- » [Naloxone leave-behind programs](#). First responders leave naloxone and other resources behind for people who have experienced, or are at risk of experiencing or witnessing, a drug overdose, regardless of whether the overdose survivor is transported to the hospital. As with other approaches, naloxone leave-behind programs are most successful when they incorporate collaborations with community partners.<sup>108</sup> Research on naloxone leave-behind programs also suggests that engaging an individual’s family member or other individuals at the scene of an emergency may facilitate engagement in additional services.<sup>74</sup>

Outreach approaches are usually conducted by a multidisciplinary team that may consist of a behavioral health provider or person with lived experience, either in addition to, or in place of, first responders. Available literature on outreach approaches suggests that more assertive strategies, like active outreach and post-overdose outreach, may be promising methods for engaging PWUD in substance use services or treatment, improving the general health of participants and reducing subsequent drug overdose risk.<sup>83,109-110</sup> A randomized controlled trial of one program demonstrated that participants who received active outreach had statistically significant higher odds of receiving any treatment, as well as significantly more days of treatment, than those who were assigned to a passive referral control.<sup>111</sup> The table below provides examples of programs that use outreach approaches.

More information about the outreach approaches, as well as case studies of programs that have been implemented throughout the United States, can be found in BJA’s COSSUP Law Enforcement and First Responder Diversion Pathways to Diversion Case Study Series on the [Active Outreach](#) and [Naloxone Plus](#) Pathways.

Examples of Outreach Approaches			
Program Name	Location	Lead Agency	Description
<b>Active Outreach Programs</b>			
<a href="#">Arlington Outreach Initiative</a>	Arlington, MA	Law Enforcement	Law enforcement data (from naloxone administration or drug-related offenses) or reports from concerned residents and officers are used to reach out to individuals in the community who recently survived a drug overdose. Through this targeted outreach, individuals are offered, over the phone or in person, naloxone and other help. The team also assists with searching for detoxification beds in treatment facilities, if individuals are ready to enter a treatment program.
<a href="#">Hope One Project</a>	Morris County, NJ	Law Enforcement	Hope One Project is a mobile recovery access vehicle staffed by a law enforcement officer, a licensed behavioral health provider, and a certified peer recovery specialist. The vehicle travels throughout the county four times a week, offering access to services and naloxone training.

### Examples of Outreach Approaches

Program Name	Location	Lead Agency	Description
<a href="#">Plymouth County Outreach</a>	Plymouth County, MA	Law Enforcement	Plymouth County Outreach is a multi-faceted collaboration among the 27 law enforcement agencies in Plymouth County and a local state university law enforcement agency, as well as recovery coaches and community organizations and coalitions, to make treatment, resources, and harm reduction tools more accessible to those living with substance use disorder and their loved ones.
<a href="#">Chelsea Hub</a>	Chelsea, MA	Law Enforcement	Chelsea Hub is a law enforcement-led initiative connecting police departments with community providers and resources in a collaborative effort to identify high-risk individuals and families using data and input from partners. <a href="#">The first of its kind in the United States</a> , the model uses teams that conduct targeted outreach and offer services before a crisis, such as a drug overdose. Since its implementation, other communities have created similar models, including the <a href="#">Plymouth, MA Hub, the first-known, county-wide hub</a> .
<a href="#">Recovery on Wheels (ROW)</a>	Cumberland County, NJ	Various	ROW is a bus outfitted to provide access to substance use services on the spot in real time, including harm reduction. Organizations and businesses (e.g., restaurants and churches) and local law enforcement host the bus throughout the month.
<a href="#">Stop, Triage, Engage, Educate, and Rehabilitate (STEER)</a>	Montgomery County, MD	Law Enforcement	STEER is a pre-booking law enforcement and drug treatment linkage program that aims to provide rapid identification, deflection, and access to treatment for drug-involved individuals as an alternative to conventional arrest. Law enforcement officers approach candidates for STEER on the scene of a non-violent offense or drug overdose. Individuals who choose to participate are assigned a care coordinator who conducts a clinical assessment and refers the individuals to treatment and other services.
Post Overdose Outreach Programs			
<a href="#">Alternative Response (AR-2) Unit</a>	Philadelphia, PA	EMS/Fire	EMS personnel and a case manager ride together in AR-2, a marked fire department vehicle, and respond when an individual revived with naloxone refuses transport to a hospital but is interested in seeking substance use services. EMS personnel determine if an individual is medically able to begin treatment, which facilitates quicker placement in a facility.
<a href="#">Drug Abuse Response Team (DART)</a>	Lucas County, OH	Law Enforcement	DART officers respond to area hospitals and communicate with drug overdose survivors, transport individuals to assessment, treatment, and other services, continue communication with them, and provide support to them and their families.
<a href="#">Post-Overdose Response Team (PORT) / Quick Response Team (QRT)</a>	Various Throughout the United States	Various	PORTs incorporate a diverse group of community partners, such as law enforcement officers, EMS personnel, and other first responders; peers; social workers; healthcare providers; and harm reductionists. Teams conduct outreach to survivors of drug overdoses within 24 to 72 hours. These programs provide harm reduction and other substance use services, reduce drug overdose mortality, and build relationships with PWUD.

### Examples of Outreach Approaches

Program Name	Location	Lead Agency	Description
<a href="#">Recovery Initiation and Management After Overdose (RIMO)</a>	Chicago, IL	EMS	EMS personnel recruit survivors of drug overdoses into services that provide MOUD. Linkage managers or peer outreach workers will then conduct outreach to individuals and connect them with services.
<b>Naloxone Leave Behind Programs</b>			
<a href="#">Coordinated Overdose Response and Engagement (CORE)</a>	Lexington County, SC	EMS	After administering naloxone, EMS personnel leave a CORE Care Pouch for individuals, which includes a resource card and a disposable, pre-paid cell phone programmed with a local recovery organization's phone number. Within 72 hours, a recovery specialist calls the cell phone and offers referrals to substance use and other services. If the individual does not respond to three outreach attempts, EMS personnel will team with a recovery specialist to conduct a home visit.
<a href="#">State-Wide Naloxone Leave-Behind</a>	Massachusetts	EMS	In Massachusetts, EMS can receive approval from their Affiliate Hospital Medical Director to stock ambulances with naloxone kits that can be left with an individual who has recovered after successful treatment for a potential opioid overdose, after patient transport begins or if they refuse transport. The individual and anyone accompanying the individual are given the kit and instructions on how to use it. Ambulance services must have a written policy to use this protocol, and training is required for EMS personnel.

### Community Paramedicine Approaches

**Community paramedicine** programs are an extension of traditional pre-hospital EMS that use specially trained personnel to provide follow-up services to individuals who have experienced a medical emergency, to support access to care and prevent repeat incidents. This model, which is a form of, and may also be referred to as, Mobile Integrated Health (MIH), was developed to provide health care for individuals with many types of chronic conditions, unrelated to substance use, and potentially to improve rural community health care.<sup>112</sup> However, variations to traditional community paramedicine approaches have increasingly been used to support PWUD, and this approach has become an effective model for harm reduction.

Implementing community-based paramedicine and harm reduction follow-up procedures with PWUD and do not wish to pursue treatment may include activities like arranging for, or dispensing, temporary doses of MOUD between an emergency incident and treatment appointment or providing education and medical care to prevent or treat substance-related infections. Community Impact North Carolina has a brief overview on implementing [Community Paramedicine to Help People Who Use Substances](#) that contains helpful tips and resources, and the National Association of State EMS



Officials (NASEMSO) collaborated with BJA's (COSSUP) to [compile examples of community paramedicine and other approaches EMS have been using to support PWUD](#).

Large-scale adoption of community paramedicine programs to support PWUD has the potential to expand access to substance use services.<sup>113</sup> These programs may also decrease unnecessary EMS transports and reduce the number of service calls.<sup>114</sup> Research on these approaches has mostly focused on EMS-initiated buprenorphine programs, where community paramedics administer MOUD to individuals who use opioids.<sup>115-119</sup> Findings suggest that individuals who receive buprenorphine in these programs experience fewer withdrawal symptoms and have greater odds of engaging with a treatment program, greater treatment retention, and may have greater success entering and remaining in recovery.<sup>115,118-119</sup>

The table below details EMS-initiated buprenorphine programs, as well as other similar community paramedicine approaches implemented throughout the country to support PWUD.

Examples of Community Paramedicine Approaches			
Program Name	Location	Type	Description
<a href="#">Austin-Travis County EMS Community Health Paramedic (CHP) Program</a>	Austin-Travis County, TX	Pre-hospital initiation of buprenorphine; Linkage to substance use treatment and services; Case management for EMS high utilizers	When available, Austin-Travis County CHP personnel respond to service calls for opioid overdoses to establish a connection with the patient or their friends and support network. <sup>120</sup> If CHP personnel cannot respond, they follow up with the patient within one day. Follow-up services may include administration of buprenorphine to individuals experiencing opioid withdrawal. Generally, this service is provided for up to seven days while an individual awaits placement in a MOUD program. <sup>121</sup> Other follow-up services may include connecting individuals to MOUD, providing them with opioid overdose rescue kits, and the use of a CHP case manager to assist some high utilizer individuals with accessing other health, housing, and support services. <sup>120</sup>
<a href="#">Buprenorphine Field Initiation of ReScue Treatment by Emergency Medical Services (Bupe FIRST EMS)</a>	Camden, NJ	Pre-hospital initiation of buprenorphine	Bupe FIRST EMS units use buprenorphine to treat withdrawal symptoms in individuals revived with naloxone. Individuals then receive follow-up services the next day and are connected to long-term care and services. EMS personnel receive education and tools to promote patient engagement, including lectures, observation, and testing. <sup>116</sup> Early success of the program resulted in authorization in June 2019 for EMS throughout the state to administer buprenorphine. <sup>122</sup>
<a href="#">Emergency Medical Services Buprenorphine Use Pilot (EMS BUP)</a>	Contra Costa County, CA	Pre-hospital initiation of buprenorphine; Opioid overdose receiving center	EMS BUP is an EMS model for treating patients with opioid use disorder. Paramedics provide pre-hospital initiation of buprenorphine treatment, which provides patients immediate relief from withdrawal, stabilizes them, and protects against overdose. EMS BUP also includes sharing data on EMS patients with the county public health department, a naloxone leave-behind program, and the designation of a local hospital as an opioid overdose receiving center. The designated hospital has an integrated opioid use disorder program, and EMS personnel can transport patients who experience an opioid overdose or withdrawal symptoms there. <sup>123</sup>

## Examples of Community Paramedicine Approaches

Program Name	Location	Type	Description
<a href="#">San Antonio Fire Department/ Mobile Integrated Healthcare (SAFD/MIH) Program</a>	San Antonio, TX	Pre-hospital initiation of buprenorphine; Linkage to substance use treatment and services	The SAFD/MIH Program can provide in-field induction of buprenorphine to individuals experiencing opioid withdrawal, which serves as a temporary bridge to get the patient into a treatment program. EMS personnel also follow up with individuals who have experienced a recent drug overdose and provide them with treatment linkage support and an opioid overdose kit, together with training on its use. <sup>124</sup> Other community paramedicine programs include establishment of an acute care station that helps navigate and triage patients who need medical care during overnight hours, as well as distributing taxi vouchers to citizens who need them, so people can access transportation for non-emergency care, freeing EMS personnel for emergencies. <sup>124-125</sup>
<a href="#">San Francisco Fire Department's Alternate Destination – Sobering Center Project</a>	San Francisco, CA	EMS alternative destination program	The Alternate Destination is a community-based sobering center to which an acutely intoxicated person is transferred if found eligible by a paramedic following an assessment, and if the patient agrees to the transfer. <sup>126</sup> A group of paramedics are specially trained to provide feedback to EMS personnel responding to service calls on how to screen individuals for transfer eligibility to a Sobering Center. The center that partnered with the community paramedicine program is staffed by medical assistants and registered nurses who monitor patients. Other staff, like social workers, connect patients to substance use treatment, as well as housing and other entitlement programs. Most individuals are discharged from the center within 4 to 12 hours. Other community paramedicine programs include a city-wide “frequent EMS user” team that meets with individuals and helps connect them with services, and a Street Overdose Response Team (SORT), their version of PORT. <sup>127-128</sup>
<a href="#">Stanly County EMS Community Paramedic Division</a>	Stanly County, NC	Pre-hospital initiation of buprenorphine; Linkage to substance use treatment and services; EMS alternative destination program; PORT; Naloxone leave-behind	Stanly County EMS launched their Community Paramedic Division in May 2019 to respond to the opioid crisis. In addition to community paramedics, the team includes a peer support specialist and social work intern. All community paramedics receive training on PORT, crisis intervention team (CIT), MOUD waivers, motivational interviewing, clinical withdrawal, and advanced assessments, such as blood draws, wound care, and ultrasounds. The Division offers a range of other services that include community education; harm reduction, including naloxone distribution, a partnership with a local syringe service program, HIV/ Hepatitis C testing, and field buprenorphine induction; assisting patients with transportation to appointments and telehealth visits; EMS alternative destination options to the emergency department; same-day referrals to MOUD treatment; and linking patients to other healthcare and support services. <sup>129-130</sup>

## Examples of Community Paramedicine Approaches

Program Name	Location	Type	Description
<a href="#">Pittsburgh Bureau of EMS Pre-Hospital Buprenorphine Pilot Program</a>	Pittsburgh, PA	Pre-hospital initiation of buprenorphine; Linkage to substance use treatment; Naloxone leave-behind	The Pittsburgh Bureau of EMS launched the Pre-Hospital Buprenorphine Pilot Program in November 2021, becoming the third EMS program in the country to administer buprenorphine to patients experiencing opioid withdrawal. <sup>131</sup> The program does not require transport to an emergency department and connects patients to low-threshold treatment via telemedicine. <sup>132</sup> Specifically, patients can schedule a virtual follow-up appointment with a doctor at the University of Pittsburgh Medical Center within 24 hours of the EMS encounter, receive a prescription for buprenorphine, and be connected to other harm reduction resources. <sup>131</sup> EMS personnel also distribute naloxone leave-behind kits. <sup>133</sup>



## RESOURCES

Several organizations have compiled resources and toolkits with information and documents that can be referenced when establishing community paramedicine programs, including:

- [National Association of Emergency Medical Technicians \(NAEMT\)](#)
- [California Emergency Medical Services Authority](#)
- [Minnesota Department of Health](#)
- [Rural Health Information Hub](#)
- [Nevada Department of Health and Human Services](#)
- [Lebanon Fire Department and Dartmouth Hitchcock Medical Center](#)

In addition, the California Paramedic Foundation has a [Risk Assessment and Programming Toolkit](#) that communities can use to highlight areas of shared interest to drive collaborative programming specific to substance use as well as other chronic conditions.

## Diversion Approaches

The [Sequential Intercept Model](#) details how PWUD and individuals with mental health conditions enter, and move through, the criminal justice system. It also identifies strategies, known as diversion approaches, to divert people who have encountered, or entered, the criminal justice system away from arrest or criminal charges, and towards treatment. Thus, these approaches provide alternatives to traditional policing strategies, which are not effective in reducing recidivism and potentially increase the risk of a future fatal drug overdose.<sup>134</sup>

In diversion approaches, charges against an individual may be suspended or dismissed upon successful completion of a treatment program, where they receive a range of services under a coordinated plan that maximizes opportunities for change;<sup>135</sup> however, their record may indicate an arrest was made or a citation issued.<sup>136</sup> Individuals who do not participate in or complete the program or reoffend may be subject to criminal charges.<sup>136</sup>

Diversion may occur at different points along the criminal justice system continuum. For example, pre-arrest diversion occurs at one of the earliest points in the criminal justice system continuum, where law enforcement officers can offer an individual a treatment program as an alternative to arrest. In contrast, pre-charge and pre-trial diversions occur further along the criminal justice system continuum—after an individual has been arrested, but before they are charged or prosecuted. These approaches divert individuals from further criminal justice system involvement by allowing them to complete programs so they can enter a plea or remain in the community instead of being incarcerated.<sup>137</sup>

Diversion programs are generally well received by both law enforcement officers and participants.<sup>138-141</sup> Many of these programs have demonstrated positive outcomes, such as preventing recidivism and related harm, improved health for participants, and decreased costs to society.<sup>142-144</sup> However, their effectiveness is limited by the resources and other services and supports available in the community.<sup>138,144-145</sup>

The table below includes examples of programs that use, or were developed as, diversion approaches.

Examples of Diversion Approaches			
Program Name	Location	Type <sup>c</sup>	Description
<a href="#">Civil Citation Network</a>	Leon County, FL	Diversion	Instead of arresting the individual, the law enforcement officer has the discretion to issue a referral to the civil citation program, which offers qualified individuals an opportunity to link with services, including behavioral health providers and education sessions. Participants who complete the required civil sanctions (e.g., community service) and assigned treatment never have their charges filed.
<a href="#">Clean Slate</a>	Deschutes County, OR	Diversion	Clean Slate emphasizes physical health to reduce substance use. Individuals who are suspected of being in possession of a controlled substance are eligible for the program. Participants must attend an orientation meeting where they are assessed by a substance use disorder counselor and, depending on the results, may be referred to a primary care provider. Cases are not filed if participants avoid receiving additional citations and comply with their provider’s medical recommendations over a 12-month period.
<a href="#">Kākāēcec Program</a>	Menominee Indian Tribe of WI	Diversion	The Kākāēcec Program is a diversion program developed for non-violent offenders and operated by the Menominee Tribal Police Department. The tribal prosecutor makes referrals, and the tribal judge orders the individuals to the program. Those who successfully complete the program have their charges dismissed. The program is part of the tribe’s larger “Trails to Recovery” initiative, which also includes a community resource center, a wellness center, law enforcement-led crisis services, and other resources for PWUD.

<sup>c</sup> Some of the programs presented in this table evolved out of diversion approaches but may not currently be operating as such depending on how the program and its components have been implemented in different jurisdictions.

### Examples of Diversion Approaches

Program Name	Location	Type <sup>c</sup>	Description
<a href="#">Law Enforcement Assisted Diversion (LEAD)</a>	Seattle, WA	Diversion	Instead of prosecution and jail time, individuals convicted of low-level drug and other crimes are connected to case managers who can provide crisis response, psychosocial assessment, and long-term services like substance use treatment and housing. The first LEAD program was developed in Seattle, Washington, and there are now LEAD programs in more than 20 states. Many <a href="#">LEAD</a> programs have expanded beyond drug-related offenses to meet broader behavioral health needs. LEAD may also be referred to as <a href="#">Let Everyone Advance with Dignity</a> .
<a href="#">Madison Area Addiction Recovery Initiative (MAARI)</a>	Dane County, WI	Diversion	The MAARI program, which began on September 1, 2020, targets Dane County residents who committed an eligible, non-violent, low-level crime that is connected to their substance use. Eligible MAARI participants are issued a citation and referral form. The officer explains the program, and if individuals agree to be referred to treatment, the charge is not submitted to the prosecutor's office. After six months, if individuals complete the program and have no additional arrests, the original offense is dismissed permanently.
<a href="#">Operation Helping Hand (OHH)</a>	Bergen County, NJ	Diversion	In 2016, OHH began in Bergen County as a diversion program where law enforcement officers arrested individuals purchasing narcotics and then immediately offered to connect them to care; however, charges were not dropped for those who accepted help. In 2018, the program was scaled up to all 21 counties in the state, and communities were able to tailor the program depending on their circumstances, with some choosing to operate traditional, arrest-based programs, and others electing to pursue non-arrest means.





## RESOURCES

Additional resources on law enforcement-specific approaches include:

- [COSSUP](#) has compiled a resource library containing a range of materials that provide examples of foundational documents submitted by existing first responder deflection programs from across the United States.
- The [Police Assisted Addiction & Recovery Initiative \(PAARI\)](#) is a national nonprofit organization that supports law enforcement and first responder deflection programs through technical assistance, connection to training, capacity building, and resource gathering. They also hold [informational webinars and events](#) throughout the year.
- The [Treatment Alternatives for Safe Communities' \(TASC's\) Center for Health and Justice](#) compiles, consolidates, and communicates findings that help improve policy, practice, and outcomes at the intersections of health and justice.
- The National Council for Mental Wellbeing has several publications on deflection, including [Deflection and Pre-Arrest Diversion: Applying a Harm Reduction Approach](#) and [An Overview of Deflection and Pre-Arrest Diversion to Prevent Opioid Overdose](#). Related publications can be found on their [website](#), as well as links to several other [tools and resources](#).
- The Civil Citation Network has compiled [tools and resources](#) related to deflection and pre-arrest diversion.
- The JCOIN Training and Engagement Center offers an online course on [First Responder Deflection: A Warm Handoff to Services in the Community](#).
- The White House released a [Model Law Enforcement and Other First Responder Deflection Act](#), a resource that encourages jurisdictions to develop and implement deflection programs and policies.
- The Legislative Analysis and Public Policy Association (LAPPA) compiled a [Summary of State Laws](#) for deflection programs.



## Chapter 4.

# Considerations for First Responder Initiatives to Support People Who Use Drugs

## 4.1 Key Considerations

Several considerations are key to implementing strategies and approaches to assist people who use drugs (PWUD), improve their access to substance use services, and enhance overall community health and safety. Attention to these considerations will help mitigate potential challenges and barriers that communities may encounter when developing and implementing public health approaches, such as those discussed in [Chapter 3](#).

The considerations presented in this chapter were based on practice issues identified from the literature reviewed for previous chapters of this guide, as well as information shared by first responders based on their experiences working in community settings. The considerations are grouped into three categories, representing three stages of program development.



### At a Glance...

This chapter summarizes key considerations during the planning, implementation, and maintenance phases of initiatives to support PWUD. Use the links below to advance to the section(s) of interest.

#### [Planning Considerations](#)

- [Obtain buy-in and support](#)
- [Eliminate stigma and dispel myths](#)
- [Maximize resources](#)

#### [Implementation Considerations](#)

- [Engage PWUD and build trust](#)
- [Address unique challenges in rural areas](#)
- [Prioritize health equity](#)
- [Data sharing and privacy concerns](#)

#### [Maintenance Considerations](#)

- [Ensure provider wellness](#)
- [Plan for sustainability and ensure financing](#)

## 4.2 Planning Considerations

### Consideration: Obtain Buy-In and Support

Visionary leadership and agency buy-in and support are paramount to any organizational or practice change effort. High-level leadership may help drive agency priorities and facilitate implementation of first responder-led initiatives to support PWUD.<sup>75</sup> Programs that do not maintain leadership and agency buy-in may result in challenges that can lead to the dismantling of such initiatives.<sup>146</sup>

When considering implementation of a public health approach supporting PWUD, first responders are more likely to be engaged if their agency leadership is positively promoting practices and approaches to connect this population to substance use services and other supports. Leadership can communicate and promote messaging about how these new practices and approaches can enhance community well-being and help to institutionalize these strategies into everyday operations.

Additional strategies to promote buy-in and support include:

- Seek support and engagement of agency leadership and public health coalitions in planning and implementing new programs and practices.
- Communicate how the new program or practice will help the agency fulfill its mission to the community.
- Share information on how the program or practice has been effective in other similar communities or how a pilot program has been successful in this community.
- Anticipate potential resistance or barriers to implementation and discuss how they will be prevented or overcome.
- Emphasize the benefits to first responders, such as fewer drug overdoses and transports to emergency departments.
- Identify how to reduce the potential burdens of the program or practice, such as reducing or limiting paperwork, or introducing automated processes or other methods to improve efficiency.
- Identify a leader who can champion the initiative and provide guidance to others. In some communities, first responders may not have clear or consistent leadership or agency guidance—for example, those with volunteer agencies where a new president or chief may be elected annually. In these communities, local and state agencies, such as public health departments or prosecutors' offices, may be more appropriate leaders for these initiatives.

### Consideration: Eliminate Stigma and Dispel Myths

There are many myths and misinformation around substance use and PWUD that contribute to stigma toward these individuals among both first responders and communities. These negative attitudes and misinformation may result in first responders, and even bystanders, withholding or delaying care to someone who needs it, leading to potentially negative effects on individuals and the emergency response system.

Education and training, anti-stigma and anti-discrimination campaigns, communication campaigns, and first-hand experience interacting with people in recovery can help reduce myths and correct misinformation. For example, drug overdose training programs for first responders can lead to significant improvements in knowledge and positive changes in attitudes.<sup>147</sup>



#### RESOURCES

The [Police Assisted Addiction Recovery Initiative \(PAARI\)](#) created a [video](#) to dispel myths among first responders, and many organizations have materials, trainings, and other resources to dispel myths and reduce stigma, like [this flyer](#) debunking myths around naloxone use.

The table below lists examples of common myths related to substance use and the actual truths.

Dispelling Common Myths Related to Substance Use	
Myth	Truth
First responders may be exposed to fentanyl during an emergency, either through skin via touch or through the lungs by breathing it in, which can result in drug overdose or other harm to the responder. <sup>148</sup>	Misinformation about fentanyl exposure is often uncorrected. <sup>148</sup> However, the American College of Medical Toxicology and American Academy of Clinical Toxicology have found no evidence that fentanyl can be absorbed through contact with the skin or inhaled through the lungs if it becomes airborne during a routine service call. <sup>149</sup>
People who misuse opioids will continue to do so, may use more opioids, or will be deterred from seeking treatment, because naloxone is available to prevent drug overdoses. <sup>150-152</sup>	Naloxone administration has not been found to lead to increased substance use, <sup>150-151</sup> and there is no evidence that suggests naloxone use is a barrier to entering treatment. <sup>152</sup>
Medications for opioid use disorder (MOUD) just substitute one addiction for another. <sup>153</sup>	MOUD is like other medications taken for chronic conditions and is often a crucial tool for treating opioid use disorders. MOUD helps relieve withdrawal symptoms and reduce cravings to use opioids. <sup>1</sup> MOUD is considered highly effective treatment for opioid use disorder.
Addiction is a choice, and people can stop if they want to. <sup>154-155</sup>	Individuals may elect to use different substances, but becoming addicted to them is not a choice. There are many different individual, environmental, and societal factors that influence if a person's substance use results in the development of a substance use disorder. <sup>1</sup> And, like other conditions, treatment may be needed.
Treatment for substance use does not work. <sup>154-155</sup>	If first responders stop seeing the same PWUD, they may assume it is because the individual experienced negative consequences related to their substance use, instead of having received treatment. There are many different types of effective treatments for substance use, and many people can, and do, recover. <sup>1</sup> If first responders stop seeing the same PWUD, it may be because individuals have received treatment and are now in recovery. First responders should not assume it is because the individual experienced negative consequences. The National Institute on Drug Abuse has a research-based guide focused on <a href="#">Principles of Drug Addiction Treatment</a> .
It is acceptable to refer to PWUD as junkies, addicts, and other disparaging terms because the language first responders use to describe PWUD does not affect them.	Using disparaging terms perpetuates stigma. Stigmatizing language is dehumanizing and hurtful. Person-first language should always be used to describe PWUD because it distinguishes the individual from their behavior and the negative connotations associated with it. <sup>156</sup> Even though this seems like a small action, it can make an impactful difference for PWUD.
First responders only need to address the incident for which they are called; for example, if an individual experiences a drug overdose, they only need to treat the person's symptoms, stabilize them, and then transport them for further care.	First responders have an opportunity to "break the cycle" for PWUD by offering them resources and other assistance. <sup>157</sup> While first responders may not be trained on this approach or be aware of the available resources, learning how to break the cycle may make a difference to the individual, as they may not have interactions with any other healthcare provider.

## Consideration: Maximize Resources

A lack of resources can severely hinder the success of first responder-led initiatives to support PWUD,<sup>145,158-159</sup> even when they are successful in providing an effective entry point to services<sup>76</sup> and are well-received.<sup>76,138</sup> Barriers to the continued success of these initiatives include<sup>138,145,159</sup>:

- Systemic resource constraints, including an inadequate number of service providers
- Limited number of treatment facilities available, leading to difficulty securing long-term treatments and supports
- Lack of robust social services and supports, particularly housing

These overarching resource issues create a barrier to long-term recovery<sup>76</sup> and warrant a larger discussion on how communities as a whole can support individuals in or seeking recovery.

Multi-sectoral collaboration is one strategy that can maximize resources and improve care coordination for individuals.<sup>138</sup> In the context of first responders, multi-sectoral collaboration can include developing partnerships with behavioral health clinics or other treatment programs, hospital emergency departments, and other relevant organizations. While collaboration is an effective approach that improves the ability of first responders to connect individuals with relevant services, additional strategies are needed to address persistent resource challenges. First responders should be an integral part of recovery-oriented systems of care, which are person-centered networks of community-based services and supports to address the full spectrum of substance use problems.<sup>160</sup>



### TIP: Coordinate With Public Safety Answering Points

First responders and their partners can work with their public safety answering points—the centers responsible for dispatching law enforcement, fire, and EMS—and other regional and national referral sites when implementing strategies and approaches to support PWUD. These resources include 911 (a national number that can be called in a medical or similar emergency), 988 (a national number that can be called or texted during a behavioral health crisis), and 211 (a national number that can be called to access essential services ranging from rental assistance and health insurance to community meals and recreation programs). Public safety answering points and referral sites should be aware of the strategies and approaches first responders are using to support PWUD so they can coordinate and share resources, as appropriate, and determine any potential impacts on their operations.

## 4.3 Implementation Considerations

### Consideration: Engage PWUD and Build Trust

PWUD are often considered a “hard-to-reach” population because these individuals may be challenging to identify. They often do not want to self-identify as users of illicit substances or are not ready to engage in treatment or other substance use services. In addition, socioeconomic factors like homelessness and other transitory situations (e.g., housing instability, job instability) may make it difficult to contact or connect with these individuals, and people experiencing homelessness often do not have identification.

These factors can make some approaches for connecting PWUD to services, like outreach, more difficult. Even if individuals are reachable, PWUD may be hesitant to engage in discussions about their needs because they are at different levels of readiness to receive services. They may also be reluctant to work with

first responders, especially law enforcement, because they may perceive them as threatening due to previous negative interactions or out of fear of arrest or other consequences if they disclose their substance use.

Engaging with PWUD is vital for identifying needed services and ensuring they can access these services. Ideally, communities will include PWUD and individuals with lived experience in recovery in planning and engagement efforts. They are best positioned to understand the needs of PWUD and form connections, along with other community partners. Incorporating a variety of partners will add diverse perspectives that can increase engagement by building trust and establishing relationships in the community that may serve as a bridge to future services.

Communities seeking to engage PWUD should consider the following strategies:

- Law enforcement and their partners can consider development of an advisory board, or a similar advisory group, to guide their efforts. It should include representation of PWUD and individuals with lived experience in recovery, who, when possible, should be invited to serve in a leadership role.
- Work with partners or the advisory board to identify a range of substance use and other support services within the community and offer services to PWUD that are responsive to their level of readiness. These services may include harm reduction, such as drug overdose education, syringe services programs (which provide clean syringes and disposal for used syringes), and the distribution of naloxone, fentanyl test strips, and safe smoking supplies. Services may also include traditional substance use and/or mental health treatment, as well as other supports that facilitate recovery, like case management, benefits enrollment, assistance with housing, education, childcare, or support groups.
- First responders and their partners may also help address basic needs of PWUD, such as through distribution of hygiene kits. Some individuals may lack basic personal care items and other necessities; providing these items is one way to connect with this population.
- Work with partners or the advisory board to develop policies that define how first responders, particularly law enforcement, engage with individuals who have arrest warrants. Due to policies and state statutes, outreach programs led by law enforcement may require a check for warrants prior to conducting outreach, and the course of action that officers should take must be clearly defined and communicated. Many outreach programs led by law enforcement have successfully worked through the challenges and barriers associated with warrant checking practices. Options may include conducting outreach without addressing the warrant (if allowed by policy, statute, legislation, or regulation), delaying outreach, arrest, or taking a course of action depending on the situation at the time.<sup>162</sup>
  - If warrants are checked, there should be a process in place that allows the warrant to be re-docketed, or refiled. In the event a warrant cannot be re-docketed, there should be additional processes to notify correctional facilities and arrange for the receipt of services while incarcerated, as well as upon re-entry.
  - If it is determined that an arrest must be made, it is a best practice for law enforcement to initiate the arrest warrant through normal procedures (such as through the patrol division or warrant team). Officers responsible for conducting outreach to engage PWUD should not be involved in the arrest unless an emergency exists. Many officers and outreach teams have relationships



### TIP: Identify Innovative Strategies for Engagement

First responders can implement innovative approaches to help engage PWUD. For example, in Lexington, South Carolina, the [Coordinated Overdose Response and Engagement \(CORE\)](#) program leaves pre-paid, disposable phones with individuals who have experienced a drug overdose so a certified recovery specialist can follow up with them.<sup>161</sup>

with partners and judges, drug court judges, and others that allow for a consistent practice to be implemented if an arrest warrant must be initiated while still offering outreach-related services after the warrant is served.

- Partners should engage with one another to learn professional requirements, including statutory requirements, within each team’s profession. Many states require mandatory arrests for specific scenarios, including the existence of arrest warrants. All states have statutory requirements for mandating the reporting of suspected abuse or neglect scenarios.
- Warrant checking practices should be limited or, at a minimum, clearly communicated to individuals and the community to avoid potential unintended negative consequences, like arrest, that may become a barrier to individuals receiving services.<sup>162</sup>
- First responders and their partners who provide mobile outreach should be dressed in street clothes, using unmarked vehicles, and meet people in a place that is comfortable for them. If possible, have peers or behavioral health providers speak with PWUD about their substance use. This approach can help reach a population that is difficult to engage and decrease fears of arrest.

## Consideration: Address Unique Challenges in Rural Areas

Rural areas often have limited substance use and other service providers.<sup>163-165</sup> Those that are available may not provide a comprehensive range of services. For example, substance use treatment facilities in rural areas are less likely to provide buprenorphine or additional support services like case management and recovery groups.<sup>166-167</sup>

Obtaining services that do exist may be difficult due to heavy provider caseloads, lack of transportation and/or childcare, and other accessibility issues.<sup>166,168</sup>

These barriers are often compounded by circumstances more specific to the context of rural living, such as limited specialized treatment providers and fear of knowing their provider.<sup>167,169-173</sup> Individuals in rural areas may also report experiencing more stigma than do urban residents, with individuals expressing concerns that receiving substance use services may result in the loss of friends or fewer opportunities.<sup>174</sup> Increased stigma in rural areas can result in reduced backing for substance use services and supports in areas where they may already be lacking.<sup>174</sup> These barriers, combined with others, such as delayed response times and volunteer agencies that may experience a lack of resources, can have a significant negative impact in these communities.

The unique challenges of addressing substance use in rural areas may be mitigated using some of the following methods:

- Train and involve as many employees as possible to reduce the burden on any one person, and reduce potential disruptions to service because of staffing.<sup>175</sup>
- Establish agreements with organizations that can provide services remotely using telehealth or provide mobile services. Such agreements will help broaden the available pool of providers, and may increase treatment adherence due to ease of access.<sup>166</sup>



### RESOURCES

The Department of Agriculture and the Office of National Drug Control Policy compiled a [Rural Community Toolbox](#). It contains resources rural communities can use to help address substance use, such as interactive tools to assess the impact of substance use at the county level and a treatment and services locator to identify potential partners. It also identifies opportunities for funding and links to technical assistance and trainings to help rural communities develop skills to address substance use.

- Consider implementing a hub and spoke model to meet increased demands for substance use services. In this model, an individual first receives services at a higher level of care (hub) and once stable is transferred to a lower level of care in their community (spokes). It has been shown to be highly effective for providing substance use services in rural areas like Vermont, a state that was able to greatly increase its per capita capacity to treat PWUD since implementing this model.<sup>166</sup>

## Consideration: Prioritize Health Equity

PWUD may experience social stigma and negative bias, including from individuals providing healthcare or other support services.<sup>176</sup> Health equity, which means that everyone has a fair and just opportunity to be as healthy as possible,<sup>177</sup> is needed to ensure PWUD receive the substance use services they need. To achieve health equity, society must address historical and contemporary injustices; overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities.<sup>84,177-178</sup>

Incorporating health equity approaches as part of any first responder effort to connect people to substance use services is achievable. The table below provides examples of health equity approaches that have been implemented successfully.

Examples of Health Equity Approaches	
Approach	Description
Include people with lived experience	People with lived or living experience of substance use can be important to any drug overdose response and linkage to care. <sup>179</sup> These people should always be sought out and compensated for their time. Examples of inclusion strategies are establishing peer support services, forming advisory and focus groups and health equity communities, formalizing workgroups with community partners, and ensuring people with lived experience hold leadership roles. <sup>180</sup>
Address inequities and stigma	Identify and work to address social determinants of health inequities, include people with living and lived experience, implement anti-stigma and anti-discrimination policies, promote the use of non-stigmatizing language and positive media messages, and implement training and awareness campaigns for healthcare providers, partners, decision-makers, and the general public. <sup>181-183</sup>
Track health equity indicators and make data accessible	Create core health equity indicators and collect and analyze demographic data to better understand the characteristics and circumstances of those most impacted by substance misuse and overdose. In addition to examining data on age, gender, and race, explore options to dig deeper, looking at, for example, housing, transportation access, socioeconomic status, food insecurity, language, disability, and criminal justice system involvement. <sup>180</sup> Seek to integrate these data as part of dashboards or visualizations shared with partners and disseminate data widely. <sup>180</sup> Such data sharing can help improve community understanding while also enhancing partnerships and collaboration efforts.



## Consideration: Data Sharing and Privacy Concerns

While first responder data have a variety of public health uses, these benefits must be weighed against patient privacy considerations and federal and state laws that place limitations on the use of personal health information. There are potential privacy concerns about substance use and/or drug overdose data collection among agencies, as well as sharing by agencies, as these data are not as well-protected as healthcare-related data.<sup>83</sup>

The [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) privacy rule and the Public Health Service Act's federal confidentiality rule, [42 CFR Part 2](#), are two of the most important federal laws governing how health information can be accessed and shared. Understanding the scope of these laws is an essential part of any data sharing agreement between first responders and community partners.

For example, law enforcement agencies typically are not considered covered entities under HIPAA.<sup>184</sup> Conversely, while EMS personnel are typically covered entities, this privacy rule authorizes use and sharing of personal health information if state or local laws require them to report a drug overdose and related data to public health authorities.<sup>184</sup> Relatedly, 42 CFR Part 2 typically does not apply to law enforcement, fire, and EMS agencies because their primary function is responding to emergencies and not providing diagnosis, treatment, or referral to treatment.<sup>184-185</sup> Part 2 is primarily concerned with the disclosure and use of patient records pertaining to substance use treatment.<sup>184-185</sup> Note that Part 2 does regulate how law enforcement may access and use information from a Part 2 covered entity.<sup>184</sup>



### KEY CONCEPT: Data Application

There are a few ways first responders can use data to inform substance use and drug overdose prevention efforts. For example:

- Emergency medical services (EMS) data can provide detailed information on drug overdose and other substance use-related responses. Non-fatal opioid overdose data submitted to the [National EMS Information System \(NEMSIS\)](#) can be easily accessed by communities using the [Non-Fatal Opioid Overdose Tracker](#). This dashboard can be used to look at county- and state-level incidents occurring in rolling 28- or 365-day periods, with a two-week reporting lag for non-fatal opioid overdose information.<sup>186</sup>
- Some fire agencies may document drug overdose responses using the [National Fire Incident Reporting System \(NFIRS\)](#).<sup>187</sup> These aggregate, population-level, incident-based data can track drug overdose rates, naloxone administrations, average EMS time to patient, and EMS transports to medical facilities or non-transports.<sup>187</sup>
- Data mapping tools, such as the [Overdose Detection Mapping Application Program](#), are other resources for sharing near real-time de-identified surveillance data. By identifying locations with high rates of drug overdoses, public health-related emergency response programs can target prevention efforts and resources to areas with the greatest need.
- Many states have other relevant data available too. First responders and their partners should check with their state and local officials to see what information is available. Some examples of states with robust information systems include [New Jersey](#), [North Carolina](#), [Minnesota](#), [Wisconsin](#), and [West Virginia](#).

Data can be used to inform programming and evaluate outcomes. Collecting accurate data on demographics and social determinants of health, in addition to program data, may improve patient tracking and outcomes, as well as support future life-saving intervention strategies. The Substance Abuse and Mental Health Services Administration's (SAMHSA) [Strategic Prevention Framework](#) includes information on how first responders and their partners can collect primary data to inform and evaluate their programming.

## 4.4 Maintenance Considerations

### Consideration: Ensure Provider Wellness

Working with PWUD can be stressful and emotionally taxing on first responders and may result in burnout and compassion fatigue. Burnout and compassion fatigue are both the result of repeated or chronic exposure to workplace stress and unfavorable work environments or conditions, which first responders often experience. Training for first responders may not always address topics like burnout and compassion fatigue and how to be prepared for the challenges related to their roles.

In addition, stigma around seeking support for one's mental health may exist within the first responder community,<sup>188-189</sup> creating a barrier to individuals who may benefit from such services. This barrier impacts not only the first responders themselves, but also the community that relies on the essential services they provide. Shifting the first responder culture towards one that promotes self-care and acknowledges job-related trauma, and improving resources available to them, can have a positive impact on their wellness. This shift begins normalizing and destigmatizing mental health supports in the workplace.



### RESOURCES

There are several resources available to support the well-being of first responders. The [Code Green Campaign](#) has compiled a list of resources by state for first responders seeking mental health supports. The [International Association of Chiefs of Police \(IACP\)](#) has resources available organized by specific topics, like physical health and suicide prevention, for officers and other first responders.



### KEY CONCEPT: Mental Health Supports in the Workplace

Employers should make resources and supports available and accessible for first responders who experience burnout and other job-related mental health conditions. Employers and first responders should be made aware of the warning signs of these conditions, as well as how to manage stress associated with their work. Supervisors should also know how to access resources for their direct reports and encourage first responders to speak to them, if they experience burnout or fatigue.

	Actions Employers Can Take To Support Provider Wellness Among First Responders	Actions First Responders Can Take to Support Their Own Wellness
	<ul style="list-style-type: none"> <li>● Be mindful of employees' individual workloads and rebalance as necessary to account for stressors</li> <li>● Prevent long working hours and extensive overtime</li> <li>● Ensure staff are taking vacations and time off</li> <li>● Schedule and attend regular check-ins to discuss workloads, stress levels, and needs</li> <li>● Implement regular opportunities for staff reflection, discussion, and support of one another</li> </ul>	<ul style="list-style-type: none"> <li>● Be mindful of self-care and identify activities of interest unrelated to work</li> <li>● Ensure time for activities unrelated to work and establish healthy habits around them</li> <li>● Set and keep work boundaries around time off and taking on extra work</li> <li>● Discuss cases, emotions, and challenges with other staff to cultivate a culture of support</li> <li>● Meet regularly with supervisors to discuss caseloads, stress levels, and needs</li> </ul>
		

Adapted from: Substance Abuse and Mental Health Services Administration. (2022). *Addressing burnout in the behavioral health workforce through organizational strategies*. <https://samhsa.gov/resource/ebp/addressing-burnout-behavioral-health-workforce-organizational-strategies>

## Consideration: Plan for Sustainability and Secure Financing

Financing and reimbursement are significant barriers to program **sustainability**, though specific challenges and solutions vary depending on the approach and the state agency leading the initiative.<sup>193-194</sup> For example, law enforcement agencies that rely on a mix of funding streams to develop and implement deflection programs may face fewer sustainability challenges than agencies using only one or very few funding sources.<sup>92</sup>

Agencies may also struggle when state or federal grants have application requirements they do not meet, short funding periods, or do not require sustainability planning as part of the grant. Ensuring funding for community-based substance use services is also of importance. Substance use service providers typically bill Medicaid, Medicare, or private insurance to pay for an individual's care. However, without supplemental grant funding, they may be unable to offer services to individuals who are uninsured and unable to self-pay.

Receiving reimbursement from Medicare, Medicaid, and private insurance can be vital for program sustainability. Reimbursement policies for EMS are evolving to recognize the complex needs of supporting PWUD. For example:

- Insurance reimbursement policies typically provide a strong incentive for EMS agencies to transport patients to an emergency department, even though there are instances when an individual can be treated on scene or transported to an alternative destination instead of an emergency department (e.g., behavioral health clinics or withdrawal management centers). However, as of 2022, only 14 state Medicaid agencies provide some reimbursement for EMS treatment without transport services.<sup>65,195</sup>
- In 2020, the Centers for Medicare & Medicaid Services launched the [Emergency Triage, Treat, and Transport \(ET3\) Program](#), which provides temporary regulatory waivers to maximize healthcare response to the COVID-19 pandemic. ET3 is a voluntary, five-year payment model, with 205 participating EMS agencies. Participants have greater flexibility when providing emergency care to Medicare Fee-for-Service (FFS) beneficiaries. Ambulance teams can offer transportation to non-emergency department medical facilities, including behavioral health clinics, or offer definitive care in place with a qualified healthcare partner, either at the scene of the emergency or via telehealth.<sup>37</sup> While not available everywhere, this program may serve as a model for future initiatives.
- As of 2022, in five states (Arizona, Georgia, Minnesota, Nevada, and Wyoming), Medicaid agencies reimburse for community paramedicine services, as do commercial insurance agencies in 17 states.<sup>65,195</sup>



### KEY CONCEPT: Funding

In recent years, the federal government has allocated substantially more discretionary resources to expand substance use services and address the opioid epidemic. Opioid-related lawsuits, like the [National Opioid Settlement](#), will provide a new funding source that states, tribes, communities, and other jurisdictions may use for care, treatment, and prevention programs, including expanding first responder programs for PWUD.<sup>190-192</sup> PAARI has guidance available on how [law enforcement and other first responders can access these funds](#).

## 4.5 Conclusion

First responders are in a unique position to connect PWUD to life-changing services. Incorporating strategies to better support this population can have a positive impact on individuals and communities by fostering acceptance and belonging, reducing substance use and misuse, and improving overall quality of life.

This chapter has discussed considerations for communities during the planning, implementation, and maintenance phases of developing first responder programs. Many factors will ultimately contribute to program success. Thoughtful approaches to addressing the considerations discussed here, and continuous monitoring and adjustment of programs in response to community needs, external conditions, and program experiences will aid first responders in providing the most appropriate and effective services to PWUD.





Appendices.

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## Appendix A.

# Acknowledgments

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# Best Practices for Responding to Opioid Overdoses

This appendix summarizes best practices that first responders use when responding to an opioid overdose. The information outlined here provides a broad overview of the steps first responders may take, in accordance with state and local guidelines and regulations and agency protocols.

- The response to an opioid overdose will vary depending on which professionals or paraprofessionals arrive at the scene first, as well as local protocols and regulations.
  - Some first responders can provide basic life support (BLS), while others are also able to provide advanced life support (ALS).
- Naloxone should be administered to individuals experiencing respiratory arrest along with proper airway management and ventilations; if an individual is experiencing cardiac arrest, naloxone may be administered if it does not delay the administration of high-quality cardiopulmonary resuscitation (CPR).
  - If feasible, naloxone should be administered using a formulation that allows for the dose to be adjusted, as opposed to pre-dosed, which optimizes response and decreases the probability of a precipitated withdrawal—a medical condition that may leave the person disoriented, agitated, and combative. Mitigating precipitated withdrawal symptoms through proper opioid overdose response techniques may also increase the likelihood of engaging the individual in discussions about receiving additional services.<sup>196-197</sup>
  - Non-emergency medical services (EMS) first responders and other BLS providers or bystanders may administer pre-dosed naloxone that is given intranasally or intramuscularly.<sup>198</sup> Pre-dosed intranasal naloxone is preferred to pre-dosed intramuscular naloxone, as multiple smaller doses can be given to avoid precipitating withdrawal and eliminating provider risk of needle injury.<sup>198</sup> The intramuscular route is not recommended, due to difficulty with dosing, slower time to effect, and potential exposure to needles.<sup>168</sup>
  - More detailed information about naloxone administration can be found in the National Association of State EMS Officials' (NASEMSO's) [Model EMS Protocol Relating to Naloxone Administration by EMS Personnel](#) and the [NASEMSO's Evidence-Based Guidelines for EMS Administration of Naloxone](#).
  - Other critical interventions that must be initiated before and immediately after naloxone administration include supporting airway, breathing, and circulation, which may necessitate ventilation and oxygenation.
  - It is important to note that naloxone will only address respiratory arrest. If an individual is also experiencing cardiac arrest, additional measures will be needed, as detailed below. In addition, naloxone will only work if respiratory arrest is caused by opioid consumption. In instances where the individual is experiencing respiratory arrest related to another substance or polysubstance use, naloxone administration may not revive the individual and additional measures may be needed.<sup>199</sup>
- CPR should be administered to individuals experiencing cardiac arrest.
  - Communities may establish telephone CPR (T-CPR) that can be implemented prior to the arrival of first responders. T-CPR protocols should include training for emergency dispatchers and call takers on how to identify cardiac arrest and assist bystanders at the scene with administering CPR.

- Many bystanders who witness an opioid overdose will not have standard CPR training. Implementing T-CPR protocols may significantly increase CPR rates and improve outcomes for individuals experiencing an opioid overdose.<sup>200</sup>
- For individuals in cardiac arrest, EMS should provide advanced cardiac life support (ACLS) procedures, as appropriate. This may include use of high-performance cardiopulmonary resuscitation (HP-CPR) or defibrillators. Naloxone administration is not recommended for individuals experiencing cardiac arrest if it delays resuscitation efforts.
- Depending on location, EMS personnel may be able to administer buprenorphine to individuals experiencing opioid withdrawal.
- EMS should provide transport to the most appropriate setting, as needed, for individuals receptive to receiving additional services. In this case, an assessment may have to be conducted to determine the individual's needs. First responders should be familiar with the available resources in the community, such as hospitals with specialized substance use services in the emergency department, as well as those that can assist with identifying the most appropriate placement. In some instances, EMS may be restricted to transporting individuals to the emergency department, in which case other transportation may have to be arranged by a collaborator or partner.

A chart summarizing these steps called the [Opioid-Associated Emergency for Healthcare Providers Algorithm](#) is available from the American Heart Association.

It is important for first responders to note that cardiac events that require CPR and other BLS and ALS protocols may be related to stimulant use or other substances or combinations of substances that individuals knowingly or unknowingly ingested.

## Appendix C.

# Training and Education Resource List

The following compilation of resources is intended to provide first responders with examples and resources for training on key topics presented in this guide.

### Basic Substance Use Disorder Trainings and Education:

- [Five Minutes to Help](#) is an innovative training program, developed by the New Jersey Office of Emergency Management and Rutgers School of Public Health, which aims to break the stigma of substance use disorder. The program educates first responders on proper communication with PWUD using the foundations of motivational interviewing. It covers its application when working with individuals during the critical few minutes after they are treated for a suspected opioid overdose to connect them with harm reduction, treatment, and other recovery resources available locally, regionally, and statewide. The program is available in three formats—a one-hour online, self-guided introduction class; a live or online four-hour provider course; and an eight-hour master/instructor-level class. The program provides first responders with recovery resources available on local, regional, and statewide levels to educate the patient on options for help.
- [The Substance Abuse and Mental Health Services Administration's \(SAMHSA\) First Response](#), a free, one-hour, online training course, addresses the mental and physical stressors faced by law enforcement officers, firefighters, and emergency medical services (EMS) personnel when responding to service calls involving opioid overdoses. The course is accredited by the Commission on Accreditation for Pre-hospital Continuing Education (CAPCE). This course provides evidence-based coping strategies, resources, and exercises to mitigate the impacts of these stressful events.
- [New Hampshire Fire Academy and EMS—Project First](#) uses a multi-faceted approach that includes education and training for both first responders and the community to engage individuals in activities to reduce opioid overdoses in the state.
- [First Responder Addiction and Connection to Treatment](#) is a training program within the Pennsylvania Office of Drug Surveillance and Misuse Prevention that was established to ensure first responders, public safety professionals, paraprofessionals, and their agencies have the tools necessary to respond to the opioid epidemic.
- [SAMHSA Creating Safe Scenes](#), a free, online training course, helps first responders assist individuals in crisis with mental health conditions or substance use disorder, using safe, positive approaches. It helps first responders understand more about mental health and substance use, so they can better assess risks and apply the safest strategies for taking care of themselves and the individuals they serve.
- SAMHSA's Advisory on [Expanding Implementation of Mental Health Awareness Training in the Workplace](#) provides information for organizations and individuals to assist them in the selection and implementation of behavioral health training programs for the workplace. It provides links to relevant trainings.
- [Mental Health First Aid for Public Safety](#) training was developed for law enforcement officers and related staff. It includes approaches for de-escalating incidents and how to better understand mental health conditions and substance use disorders.

- [Mental Health First Aid for Fire and EMS](#) training is geared towards firefighters and EMS personnel and teaches them how they can best assist people experiencing a mental health or substance use challenge or crisis. It also teaches skills to safely address a colleague’s mental health or substance use challenge.

#### **Stigma Reduction Trainings and Education:**

- [Reducing the Shame and Stigma of Substance Use Disorder/Addiction \(RSS-SUD\)—First Responder](#) training teaches first responders about the roles shame and stigma play in substance use disorder. First responders learn about the impacts and consequences of shame and stigma on the individual, their effects on recovery, and how to eliminate judgments and assumptions about PWUD. (Note: There may be fees associated with this training.)
- [Substance Use Disorder Stigma: What It Is and How You Can Prevent It](#) provides information on how PWUD may experience stigma, and personal actions that can be taken to reduce stigma and biases.
- [Caring for People Who Use Drugs](#) is an online training developed for EMS personnel that helps them identify current drug supply issues, the role harm reduction plays in the health of PWUD, and ways in which EMS personnel can improve treatment outcomes for PWUD. It also explains the role of language, hand-off reports, and documentation in treatment efficacy, as well as the role of EMS in community programs, public health, and fentanyl myths.
- Bureau of Justice Assistance’s (BJA) [Comprehensive Opioid, Stimulant, and Substance Use Program \(COSSUP\)](#) has a webinar on [The Deflection Conversation Framework: Adapting Language to Reduce Stigma](#) that suggests how first responders can reduce stigma when interacting with people with substance use or mental health conditions.

#### **Trauma-Informed Approaches Training and Education:**

- [Trauma-Informed First Responder Training](#) provides first responders the skills, tools, and techniques needed to identify psychological trauma, properly engage citizens with mental health conditions, and de-escalate emergency situations effectively. (Note: There may be fees associated with this training.)
- SAMHSA’s Addiction Technology Transfer Centers (ATTCs) have several resources available on [Implementing Trauma-Informed Care \(TIC\) in SUD Treatment and Recovery-Oriented Systems](#), and the Mental Health Technology Transfer Centers (MHTTCs) offer several [Trauma-Informed Care Trainings](#).
- [Operation 2 Save Lives and QRT National](#) offer several training and continuing education events on a variety of topics, including a Trauma-Informed Response Training and Trauma-Informed Responses for Public Safety-Community Collaborations.

#### **Cultural Competency Training and Education:**

- [SAMHSA Resources on Cultural Competency](#) provides several resources and online trainings from SAMHSA and other federal agencies and organizations on improving cultural competency.
- [The Department of Health and Human Services \(HHS\) Cultural Competency Program for Disaster Preparedness and Crisis Response](#) e-training equips first responders with the knowledge, skills, and awareness to serve all individuals regardless of cultural or linguistic background.
- [HHS National Standards for Culturally and Linguistically Appropriate Services \(CLAS\)](#) are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate healthcare disparities by providing a blueprint to implement culturally and linguistically appropriate services. HHS also has several other [resources on cultural health](#) available.

- The University of California–Los Angeles Opioid and Stimulant Implementation Support Training and Technical Assistance Center (OASIS-TTA) offers [Tribal/Urban Indian Provider Trainings](#) that introduce Tribal, Urban Indian, and community-based behavioral health providers to culturally driven treatment modalities and practices for American Indian and Alaska Native individuals with substance use disorder.
- The ATTCs have resources available on [Culturally Competent Service Delivery](#) and [Building Health Equity and Inclusion](#).
- The [Center of Excellence in LGBTQ+ Behavioral Health Equity](#) has developed [guidance for language](#) to use related to sexual orientation, gender identity, and expression for behavioral health providers that first responders can reference to better understand the most recent language these communities are using.

#### **Harm Reduction Training and Education:**

- [Naloxone for First Responders](#) training course, hosted by the New Hampshire Fire Academy and EMS, provides first responders with the knowledge and skills to administer naloxone to community members.
- [Naloxone and Opioid Overdose Response: A Training for Law Enforcement in Washington State](#) is a training designed to be delivered in one hour or less. A curriculum, training materials, agenda, and training slides are provided. The training provides law enforcement and other public safety professionals and paraprofessionals with knowledge on how to obtain and administer intranasal naloxone, as well as how to identify risk factors and recognize and respond to an opioid overdose. While designed for Washington State, this training can be modified to fit any state.
- [The BJA's Law Enforcement Naloxone Toolkit](#) is a clearinghouse of resources to support law enforcement agencies in establishing a naloxone program.

## Appendix D.

# Person-First Language for Substance Use Disorders and People Who Use Drugs

Using person-centered, or “person-first” language means putting emphasis on the individual as a *person* first and foremost, and not equating them and their identity with their use of substances. This creates a sense of empowerment and reduces stigmatization. Using person-first language is a good first step to eliminating biases toward people who use substances and making positive change. When first responders speak to people who use drugs (PWUD) in a person-centered and non-stigmatizing way, it can have a profound impact on how PWUD view themselves and how they view first responders; it can also affect how substance use is viewed by colleagues.

Using language that is *not* person-first, such as referring to someone as an “addict,” “alcoholic,” or “drug user,” can make a person feel stigmatized, shamed, and helpless, and can also increase bias among colleagues. Below are some common examples of person-first language and terms that should be avoided.

Person First Language (Say this...)	Stigmatizing Term (Not this...)
<ul style="list-style-type: none"> <li>• People/person who use(s) substances (PWUS)</li> <li>• People/person who use(s) drugs (PWUD)</li> <li>• People/person who inject(s) drugs (PWID)</li> <li>• People/person with/experiencing a substance use disorder</li> <li>• Person with addiction (if clinically accurate)</li> <li>• Person who occasionally uses substances/drugs</li> <li>• Person who engages in heavy episodic alcohol consumption</li> </ul>	<ul style="list-style-type: none"> <li>• Abuser</li> <li>• Addict/alcoholic/ drunk</li> <li>• Crack head</li> <li>• Drug abuser</li> <li>• Druggie</li> <li>• Intravenous drug user</li> <li>• Junkie</li> <li>• Pot head</li> <li>• Shooter</li> <li>• User</li> </ul>
<ul style="list-style-type: none"> <li>• Risky or unhealthy alcohol/drug use</li> <li>• Substance use (illicit drugs)</li> <li>• Substance misuse (prescription medications)</li> <li>• Substance use disorder</li> </ul>	<ul style="list-style-type: none"> <li>• Habit</li> <li>• Abuse</li> <li>• Drug problem</li> <li>• Dependence</li> </ul>
<ul style="list-style-type: none"> <li>• Person in recovery</li> <li>• Person with lived and living experience (PWLLE) of substance use</li> </ul>	<ul style="list-style-type: none"> <li>• Recovering addict/alcoholic</li> <li>• Clean</li> <li>• Sober</li> </ul>
<ul style="list-style-type: none"> <li>• Return to use</li> <li>• Recurrence/recurrence of symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• Relapse/lapse</li> <li>• Slip</li> </ul>
<ul style="list-style-type: none"> <li>• Treatment center/program</li> <li>• Withdrawal management</li> </ul>	<ul style="list-style-type: none"> <li>• Rehab</li> <li>• Detox center</li> </ul>
<ul style="list-style-type: none"> <li>• Testing positive (on a drug screen)/positive toxicology</li> <li>• Testing negative (on a drug screen)/negative toxicology</li> <li>• In active use</li> <li>• In recovery</li> </ul>	<ul style="list-style-type: none"> <li>• Dirty</li> <li>• Failing a drug test</li> <li>• Clean</li> </ul>

This table was adapted from multiple sources, including the [National Institutes of Health](#) (NIH) and [Shatterproof](#). For more information on using person-first language for PWUD, including a CME/CE activity, see the [NIH page on Person-First and Destigmatizing Language](#).

## Appendix E.

# Dialogue for First Responders and Related Resources

The following compilation of resources is intended to provide guidance on conducting person-centered, non-stigmatizing interactions with people who use drugs (PWUD) and with their families, as well as for assessing substance-related and other needs, and connecting PWUD to appropriate services.

Resource	Description
<a href="#">Alcohol Use Disorders Identification Test (AUDIT)</a>	Developed by the World Health Organization, the AUDIT is a brief (10-item) screening tool that primary care practitioners, healthcare professionals and paraprofessionals, and individuals can use to screen others, or themselves, for problematic alcohol use. The AUDIT is provided in both interview and self-report versions and includes illustrations and measures of standard drinks.
<a href="#">Get Connected: Linking Older Adults With Resources on Medication, Alcohol, and Mental Health</a>	<p>This Substance Abuse and Mental Health Services Administration (SAMHSA) guide was developed to increase awareness of alcohol and medication misuse and mental health conditions in older adults. It contains fact sheets and screening tools that may be useful for first responders, peers, or behavioral health providers who encounter older adults or their family members or caretakers. Fact sheets and a screening tool of specific relevance include:</p> <ul style="list-style-type: none"> <li>• <b>Fact Sheet #4.</b> An Invisible Problem: Alcohol and Older Adults: Discusses risk factors, signs, and symptoms of alcohol misuse in older adults and factors that offset risk factors and increase resistance to alcohol misuse.</li> <li>• <b>Fact Sheet #5.</b> Prevention, Intervention, and Treatment of Alcohol Problems Among Older Adults: Presents a chart that matches levels of alcohol use to prevention and treatment approaches. Also given in this chart are prevention, intervention, and treatment approaches that are suitable for different levels of alcohol consumption.</li> <li>• <b>Fact Sheet #6.</b> Prescription and Over-the-Counter Medications and Older Adults: Details medications of concern in older adults, risk factors and warning signs related to substance use or unintentional misuse, potential drug interactions, and ways to help avoid medication misuse.</li> <li>• <b>Screening Tool #1.</b> 10 Important Questions for Those Over 65: A quick screener to identify potentially problematic alcohol use among older adults.</li> </ul>
<a href="#">Pathways to Person-Centered Care</a>	This toolkit is intended to provide guidance to providers and care teams looking to improve their delivery of person-centered care. The tool is designed as a checklist, offering a range of action steps and links to related resources. Providers and teams can choose action steps best suited for their setting, resource availability, and team configuration.
<a href="#">Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma</a>	This toolkit discusses what addiction-related stigma is, why it's so prevalent, the impact of stigma on PWUD, and tips on how to reduce stigma at both the personal and organizational levels.

Resource	Description
<a href="#">Beyond Labels: Reducing Stigma Among All Moms and Babies</a>	<p>This interactive website, designed for people who work in health-related fields, helps them learn how stigma can impact both the care and support that mothers need, seek, and receive. It provides tools to assess the trainee's own stigma and biases and specific ways to reduce stigma in the workplace and community.</p>
<a href="#">Toolkit: Helping Children Impacted by Parental Substance Use Disorder</a>	<p>This toolkit was developed for adults who come into contact with children impacted by parental substance use. The publication describes adverse childhood experiences and trauma related to a parent's substance use and includes information on how to recognize such children and help them.</p>
<a href="#">Unconscious Bias Tool</a>	<p>This website provides education, tools, and resources on the impact of unconscious bias and how to assess for and address it, based on different factors like race, gender, and sexual orientation.</p>
<a href="#">Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder: A Toolkit</a>	<p>This toolkit provides information and resources for providing whole-person care to individuals experiencing both homelessness and opioid use disorder, including looking beyond an individual's substance use and focusing on the intersecting challenges and strengths that make up the whole person. Best practices on topics such as using person-first language, understanding and reducing stigma, practicing cultural humility, being trauma-informed and healing-centered, supporting harm reduction, and understanding how people change are included.</p>

## Appendix F.

# Tools for Finding Resources and Developing Resource Lists

First responders and their partners can conduct activities like resource and asset mapping to identify community resources that will support their initiatives to connect people who use drugs (PWUD) to substance use services and other supports. Understanding the resources that are and are not available is key to strategic planning. First responders should communicate and collaborate with different organizations and agencies in their community, such as local health departments, hospitals and healthcare providers, peer support agencies, behavioral health providers, and social services agencies as they work to identify community resources. Once the available resources have been identified, first responders can identify gaps and determine what additional partnerships are needed to fill these gaps, to expand services for PWUD.

The National Council of Juvenile and Family Court Judges has developed a [Targeted Resource Mapping Toolkit](#) to guide communities in mapping resources to address substance use disorders. This toolkit contains templates for developing resource maps, resource directories, and an action plan. The following resources provide additional guidance on how to coordinate and collaborate with other local service agencies to expand the services first responders can offer to PWUD.

Resource	Description
<a href="#">Public Health and Safety Team (PHAST) Toolkit</a>	This toolkit provides guidance for coordinating opioid response services between public health officials, criminal justice officials, and first responders. The resource was developed to increase collaboration and coordination across different sectors to reduce opioid overdose deaths.
<a href="#">Stop the Addiction Fatality Epidemic (SAFE) Community Playbook</a>	This toolkit from the SAFE Project is a step-by-step guide on how communities can organize, evaluate, and create change. It provides insight on how to find and develop the right team of community constituents to lead the effort, identify priorities, and put a plan of action in place.
<a href="#">The Opioid Epidemic Practical Toolkit</a>	This toolkit, developed by the Department of Health and Human Services for community leaders and faith-based organizations, but applicable to first responder agencies, provides practical strategies to bring hope and healing to communities struggling with drug problems, namely by opening doors, increasing awareness, building community capacity, getting ahead of the problem, and connecting and collaborating with others.

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