



# Naloxone Plus Framework

## Critical Elements of Post-Overdose Connections to Care

*This brief is intended to aid local planning groups, community leaders, and their partners—including law enforcement and first responders—in collaborative efforts to expand community-based substance use treatment and related service capacity. It offers critical questions to inform development of programming that coordinates access to and delivery of substance use services immediately following an overdose reversal through immediate and ongoing linkage and engagement.*

Communities across the country are working to expand access to naloxone, the lifesaving opioid overdose reversal drug. While naloxone is a critical component in efforts to combat the opioid crisis and save lives, alone it is insufficient; one study found an elevated risk of death from overdose in individuals who had recently reported non-fatal overdose.<sup>1</sup> Access to effective, low-threshold, community-based substance use treatment and supportive services, along with intensive overdose prevention interventions, are also essential.

The “Naloxone Plus” framework—a nationally recognized model for overdose response and prevention in communities hit hardest by the crisis—creates a mechanism that bridges the gap to services following an overdose reversal.<sup>2,3</sup> Engagement efforts at this precise time, during or immediately following an overdose reversal episode, leverage a unique window of opportunity to yield interest in services.

Naloxone Plus is one of the five pre-arrest diversion pathways from law enforcement and other first responders to treatment. Similar to Good Samaritan 911 laws that provide limited immunity against prosecution for drug possession when people call emergency medical services seeking help for someone who is overdosing, Naloxone Plus and other pre-arrest diversion pathways are built on a public health approach to overdose rather than a criminal justice one,<sup>4</sup> with commensurate buy-in from first responders, prosecutors, and the community that arrest is not the appropriate response.

Naloxone availability, broad distribution, and administration at the point of overdose are integral to the Naloxone Plus framework. Its process is triggered by naloxone administration, which is immediately followed by rapid engagement with the overdose survivor to offer access to community-based treatment and services. Implementation involves tight integration among all community partners, usually including law enforcement, emergency medical services and other first responders, treatment and other service providers, hospitals, public health departments, public officials, individuals and families with lived experience, community members, and other stakeholders, who collaboratively respond in a comprehensive, systems-based, urgent, and ongoing manner. The framework can be implemented to facilitate service linkages following overdose reversal whether or not they go to the emergency room, helping to maximize the number of individuals reached by the intervention.

### Critical Questions: 10 Steps of Naloxone Plus

The Naloxone Plus process has 10 steps, which together form a foundation for optimizing a community’s overdose response. The following questions are intended to spur discussions that yield and highlight important information related to a community’s current overdose response efforts, capacity to implement the Naloxone Plus framework, and opportunities that might support such implementation. Depending on

where a community is in a planning or implementation process, any specific question may merit more or less attention.

1. **Naloxone Administration:** Naloxone Plus begins with naloxone administration. First responders, individuals with substance use disorder (SUD), families, friends, treatment providers, hospitals, and the community should be trained and equipped with naloxone. Naloxone distribution should be as broad as possible. *(See step 10; because naloxone administration and distribution are closely related, many of the same planning questions apply to step 10.)*
  - (a) Do first responders have access to and carry naloxone?
  - (b) How is naloxone paid for by law enforcement, treatment providers, and public health agencies?
  - (c) Are there providers or other agencies that offer free or low-cost naloxone and training to individuals at risk of overdose and their families/friends?
  - (d) Is naloxone easily accessible to individuals with opioid use disorder, their family and friends, and the community? How?
  - (e) Has the state issued a standing order for naloxone, allowing anyone to purchase it at a pharmacy without an individual prescription?
  - (f) Is naloxone covered by Medicaid and private insurance?
  - (g) Are there opportunities for naloxone training in the community?
  
2. **Rapid Identification:** It is critical to identify overdose survivors as soon as possible following a reversal, and to make that information available to the organizations that will make immediate contact with them. Ideally, communities with Naloxone Plus frameworks in place will work toward being able to systematically identify individuals at elevated risk for overdose and work to prevent them from occurring.
  - (a) Does the community have a systematic process to flag overdose reversals in real time?
  - (b) What organizations are notified of overdose reversals (e.g., law enforcement, public health department), and when and how are they notified?
  - (c) What is the delay in time, if any, following overdose reversal until a system-wide notification to opioids is activated?
  - (d) Is there a current process for compiling or sharing overdose data?
  - (e) Do friends and family trust peer outreach workers?

**Quick Response Team (QRT), OH**

Especially hard hit by the opioid crisis, Ohio is the birthplace of programs reflecting a Naloxone Plus framework. The Quick Response Team (QRT) model is an innovative approach expanding across the state, the Appalachian Region, and beyond.

QRTs originated in 2015 in Colerain Township (near Cincinnati) in response to rising rates of fatal opioid overdoses and an identified gap in services at the critical point in time immediately following overdose reversal. The Colerain QRT is an interdisciplinary team led by the Colerain Township Public Department of Public Safety (law enforcement and emergency medical services) in collaboration with the Addiction Services Council (a local behavioral health provider that offers care coordination) and other community stakeholders. It employs a systematic response to overdose reversals, including automatic notification to the QRT.

When notified of reversals, the QRT team follows up with survivors as soon as possible, generally at the scene of the overdose to engage with them and, if interested, provide them with on-site triage, screening, and linkage to local treatment and services. If the QRT is unable to connect with the survivor during the period immediately following the reversal, the team conducts outreach in the community soon afterward. Since 2015 implementation of the Colerain QRT, successful linkages to treatment following reversal has occurred when QRT engagement happens within three to five days. During the first half of 2018, overdoses in Colerain Township decreased more than 50 percent.

In addition to post-naloxone administration care coordination, QRT distributes naloxone and community resource information, not only to individuals who have survived overdoses but also to those at risk for overdose, and to their family and friends.

Commended and promoted by the Governor's and Attorney General's offices, Ohio's QRTs have supported treatment engagement for 80 percent of participants.

3. **Immediate Contact:** Partners should implement a mechanism for notifying a care coordinator or otherwise initiating linkage to care at the time of or as soon after overdose reversal as possible. The mechanism and time period during which individuals can be identified and contacted vary, based on a community's capacity and other unique features. Communities are increasingly relying on individuals in recovery to provide the initial outreach (sometimes called peers or recovery coaches). To establish rapport with survivors, the individual who makes immediate contact should also perform rapid engagement (see step 4).
  - (a) What existing staffing patterns could support immediate contact and engagement?
  - (b) What types of volunteers would work at this point?
  - (c) What are the skills and experiences needed to perform this work?
  - (d) How will different agencies' personnel respond to one another at these early stages?
  - (e) What are the challenges involved in setting up a response protocol at such an early stage of operations?
4. **Rapid Engagement:** Survivors should be contacted and engaged by a case manager or outreach worker (possibly a peer or recovery coach) immediately following overdose reversal to prepare for connection to and initiation in community-based treatment and recovery-support services, and with assistance to address crisis needs such as food and housing assistance. Additionally, they should maintain contact with survivors who express resistance to treatment in order to facilitate access to treatment if and when they become ready and reduce risk for a subsequent overdose. (*Because this step is undertaken by the same individual who performed the previous step—immediate contact—the planning questions for step 3 carry over to step 4.*)
5. **Rapid Access to Treatment:** A broad array of low-threshold treatment options should be accessible in minutes or hours (rather than days or weeks) following an overdose reversal. If it is not possible to immediately access preferred treatment or services, measures can be put in place to support individuals in the community until treatment becomes available. A peer or recovery coach can be useful in this step to maintain engagement.
  - (a) What is the community capacity for SUD treatment and services?
  - (b) Are there treatment and services specifically tailored to opioid use, including SUD medications (see step 8)?
  - (c) Are treatment and supportive services accessible on demand, outside of traditional business hours when many overdoses occur (evenings, weekends, holidays)?
  - (d) What are treatment provider requirements for admission? What are admission and insurance requirements? Is treatment affordable, including for SUD medications?
6. **Screening and Clinical Assessment:** Each survivor's treatment needs should be measured through a comprehensive assessment to guide treatment recommendations and linkages. (Note that in cases where there is suspected treatment need but no overdose, an initial screening may be conducted to determine whether a full assessment is warranted. In cases involving overdose, the overdose itself indicates the need for a full assessment.) Decisions regarding treatment need and level/type should be made together by a qualified clinicians and individuals, and should always respect individuals' autonomy. Not every overdose survivor wants treatment, and treatment is voluntary. Overdose survivors who do not wish to engage in treatment should be provided with information about treatment and other support services in the community, and should receive ongoing outreach, peer support and engagement, education for loved ones, help identifying and addressing barriers to care, and help addressing crisis and other needs.
  - (a) What screening and assessment tools are available or used in the community by treatment and case management providers?
  - (b) Where can a screening be performed?

- (c) What kind of timeframes are involved in doing a full SUD assessment?
  - (d) Which agencies in the community offer comprehensive SUD assessment services? How is it paid for?
  - (e) How could information gathered from an assessment be shared with other agencies involved in the Naloxone Plus framework?
7. Continued Effective Integration: Early treatment and recovery requires ongoing coordination among providers and case managers to ensure treatment engagement and retention. Effective integration requires processes for joint staffing and ongoing communication among all agencies participating in the individual's treatment. Feedback loops can ensure close, rapid communication and collaboration.
- (a) What resources are there in the community for care coordination?
  - (b) How do privacy protections (HIPPA, 42 CFR Part 2) and information sharing practices impact cross-agency care coordination in the community?
  - (c) What are the electronic means by which data can be shared with partners?
8. SUD Medications: SUD medications have been found to reduce the risk of overdose and death, and to support recovery. They are usually provided in conjunction with other therapeutic care. A robust community treatment network includes access to all three medications approved by the Food and Drug Administration (FDA)—methadone, buprenorphine, and naltrexone—along with other effective therapies and support services. The decision to use medication and which medication to use is clinical, and should be made together by authorized clinicians and individuals, and based on their history, health status and needs, and other circumstances. Decisions should respect an individual's autonomy in decision-making. (See companion brief: "Ensuring an Effective SUD Service Network.")
- (a) Are SUD medications available in the community?
  - (b) If so, which medications are available? Which are reimbursable under Medicaid and private insurance?
  - (c) Are providers that can dispense SUD medications integrated with substance use treatment and other supportive services?
  - (d) Do treatment providers support the use of SUD medications?
  - (e) Do local emergency departments or triage centers offer medication induction?
9. Recovery Support Services: Beyond community-based SUD treatment, other supportive services bolster long-term recovery. Recovery support services can include peer-led individual and group support, which include approaches that may or may not emphasize abstinence, such as Twelve-Step fellowships and SMART Recovery, respectively. Other essential services that support individuals in recovery include vocational/employment training and placement, and transportation, housing, and food assistance.
- (a) Is the community "recovery friendly"?
  - (b) What community-based recovery support services exist in the community?
  - (c) Are providers of these services represented in Naloxone Plus framework planning and implementation processes?
  - (d) Are individuals with lived experience represented in Naloxone Plus planning and implementation processes? Do they include both individuals in recovery who currently use drugs and others who abstain?
10. Naloxone Distribution: Naloxone should be distributed to individuals with opioid use disorder, their family and friends, and the community at large, along with training on administration and on the signs of overdose. Providers should have naloxone on-site, and they should distribute it to

clients/patients whenever possible. (See step 1; because naloxone administration and distribution are closely related, many of the same planning questions apply to step 1.)

- (a) Are there providers or other agencies that offer free or low-cost naloxone and training to individuals at risk of overdose and their families/friends?
- (b) Is naloxone easily accessible to individuals with opioid use disorder, their family and friends, and the community? How?
- (c) Has the state issued a standing order for naloxone, allowing anyone to purchase it at a pharmacy without an individual prescription?
- (d) Is naloxone covered by Medicaid and private insurance?
- (e) Are there opportunities for naloxone training in the community?

### Conclusion

Naloxone is integral to a community's overdose response efforts but alone is insufficient to combat the opioid crisis. Communities focusing on overdose prevention should consider implementing an integrated, cross-system Naloxone Plus program to enhance their overdose response and leverage all opportunities to facilitate access to treatment and recovery support services.

#### About TASC's Center for Health and Justice

TASC, Inc. (Treatment Alternatives for Safe Communities) provides evidence-based services to reduce rearrests and facilitate recovery for people with substance use and mental health issues. Nationally and internationally, TASC's Center for Health and Justice (CHJ) offers consultation, training, and public policy solutions that save money, support public safety, and improve community health.

**TASC's Treatment Capacity Expansion Series** is designed to guide communities and concerned stakeholders in efforts to meet community demand for behavioral health services. The lead author of the series is Amanda Venables.

**Generous support for this project was provided by the Open Society Foundations.** We thank them for their commitment to this important field of work.

For further information, or to learn about CHJ's consulting and training services, contact:  
Ben Ekelund, Director of Consulting and Training  
bekelund@tasc.org or 312.573.8337

### Endnotes

<sup>1</sup> Caudarella, A., Dong, H., Milloy, M., Kerr, T., Wood, E., & Hayashi, K. (2016). Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs. *Drug and Alcohol Dependence*, 162, 51–55.  
<http://doi.org/10.1016/j.drugalcdep.2016.02.024>.

<sup>2</sup> Police Treatment and Community Collaborative. (2017). *Pre-arrest diversion: Pathways to community: Police, Treatment and Community Collaborative*. Chicago: TASC's Center for health and Justice. Retrieved from <http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/PTAC-Pathways-Visual.pdf>.

<sup>3</sup> TASC's Center for Health and Justice (2017). *Pre-arrest diversion/deflection frameworks: A decision making tool for police leaders*. Chicago: TASC's Center for Health and Justice. Retrieved from [http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/DeflectionFramework-excerpt\\_Final.pdf](http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/DeflectionFramework-excerpt_Final.pdf).

<sup>4</sup> Charlier, J. (2019). *Solutions to our nation's opioid crisis: The Naloxone Plus pre-arrest diversion framework* [slides]. Chicago: TASC's Center for Health and Justice. Retrieved from [http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/NaloxonePlusFramework\\_SlideShow.pdf](http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/NaloxonePlusFramework_SlideShow.pdf).