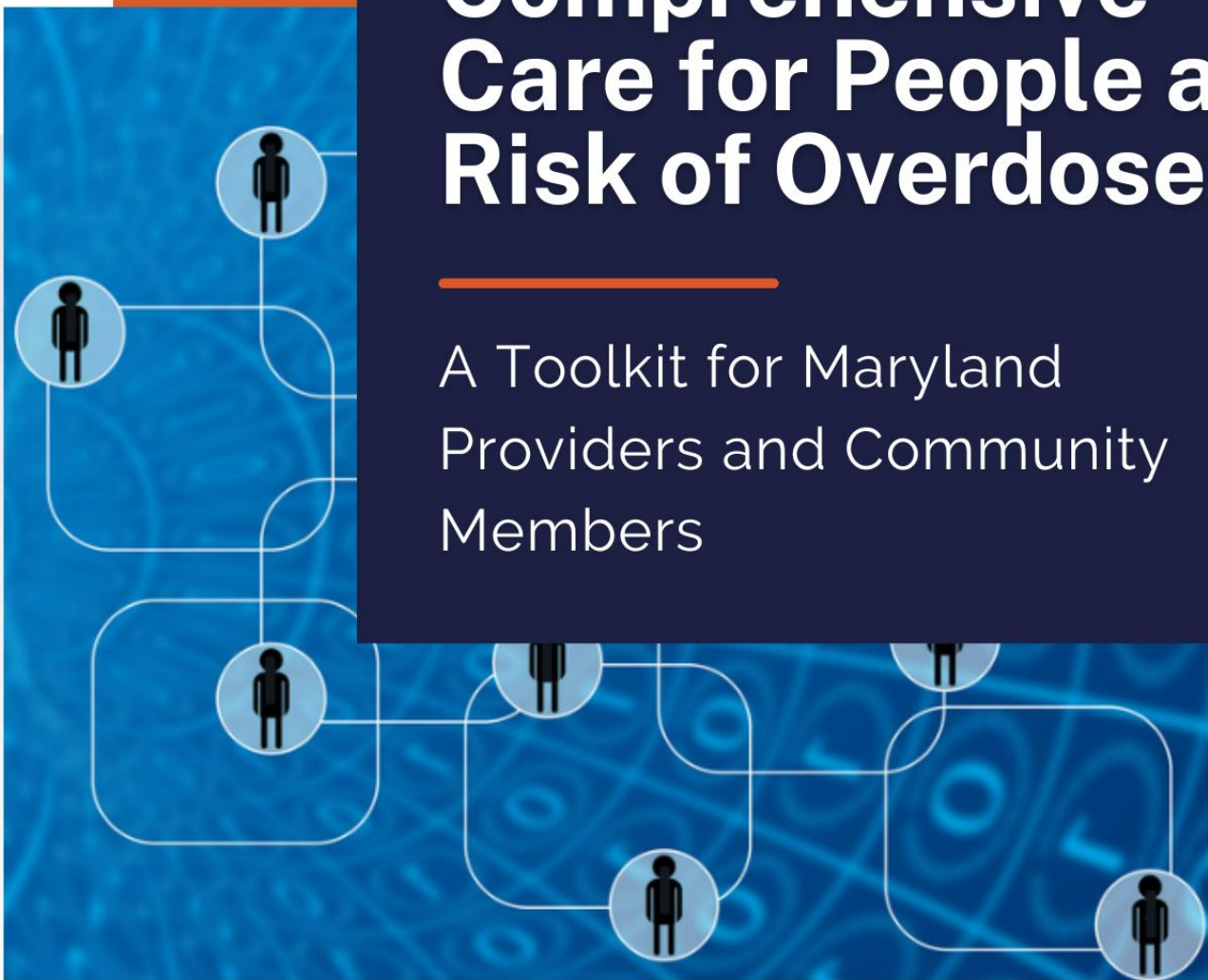


Improving Linkages to Comprehensive Care for People at Risk of Overdose

A Toolkit for Maryland Providers and Community Members



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Glossary of Terms

ACE: Adverse childhood experience

CDC: Centers for Disease Control and Prevention

HIV: Human immunodeficiency virus

ICM: Intensive case management

MAT: Medication-assisted treatment

MDH: Maryland Department of Health

MOUD: Medications for opioid use disorder

NIDA: National Institute on Drug Abuse

OD2A: Overdose Data to Action

OUD: Opioid use disorder

PRS: Peer recovery specialist

SAMHSA: Substance Abuse and Mental Health Services Administration

SDOH: Social determinants of health

SSPs: Syringe services programs

SUD: Substance use disorder

This product was brought to you by the Maryland Department of Health and the Association of State and Territorial Health Officials (ASTHO). It is funded in part by grant number CDC-RFA-OT18-18020 and specifically through CDC's Overdose Data to Action cooperative agreement.

Statement of Purpose

The Maryland Department of Health (MDH) and the Association of State and Territorial Health Officials (ASTHO) collaborated to develop the *Improving Linkages to Comprehensive Care for People at Risk of Overdose* toolkit after reviewing the findings from a series of MDH reports. Each report sought to provide a greater understanding of the experiences of Maryland citizens at increased risk for overdose between 2018 and 2020, and each report highlighted the need for improved linkages to care and greater care integration for people who use drugs. Specifically, the [Statewide Ethnographic Assessment of Drug Use and Services](#) (SEADS) report revealed that “people who use drugs in Maryland have experienced significant trauma, are in need of more accessible services, change their engagement with certain service providers because of stigma, and have established a significant support network amongst each other in response.”

Through the report, Maryland gathered firsthand perspectives of people who use drugs on what their experiences and needs are. These experiences can inform Maryland providers and communities interactions with people who use drugs. Selected direct quotes from Maryland residents who use drugs can be found in the toolkit and in the below callout boxes.



Following the SEADS report, MDH released the 2019 [Overdose Fatality Review report](#), which reflects the collective work of 17 local overdose fatality review teams seeking to understand the cause of overdose death within their jurisdictions and provide recommendations on preventing these types of fatalities. Some of the major recommendations from the Overdose Fatality Review report included:

- Establishing processes to follow-up and support individuals and families affected by overdose.
- Increasing understanding, communication, and integration of medication-assisted treatment (MAT) providers.
- Increasing harm reduction and support services for individuals and families affected by overdose.

Finally, the annual [Data-Informed Overdose Risk Mitigation report](#), which is Maryland's effort to better understand residents' relative risk of overdose death based on their interactions with health and social safety-net systems, revealed several high-level findings and policy implications for improving linkages to care. Findings included that large proportions of people who died of overdose are engaged with the healthcare system, which offers opportunities to increase comprehensive wraparound support to high-risk populations. The report also highlighted growing racial disparities in overdose-related deaths and access to opioid use disorder (OUD) treatment.

This toolkit was developed for Maryland providers and communities to establish better partnerships and improve linkages to care, and all references to “local,” “the state,” or “statewide” are specific to Maryland. However, anyone may use this document as a resource, as much of the information is applicable to communities outside Maryland. For information about program or strategy design, funding, customization, or replication, readers are encouraged to directly contact [Maryland Department of Health's Center for Harm Reduction Services](#).

Executive Summary

The drug overdose crisis in the United States continues to claim the lives of hundreds of Americans daily, and the COVID-19 pandemic has [exacerbated this deadly crisis](#). Improving linkages to comprehensive care is an essential step to reducing overdose deaths and improving quality of life for Marylanders. This includes linkages to any type of healthcare or social support an individual needs based on that individual's health priorities. Efforts to establish non-coercive linkages to comprehensive care require that providers and community members focus on building relationships and earning trust, both with people who use drugs and across the care continuum. Building strong community relationships for ongoing engagement and knowing who and where to refer people to is essential to this process. People who use drugs, along with those who provide healthcare and social services for people who use drugs; community members; and friends and family members of people who use drugs, are all important partners in improving linkages to care and mitigating overdose morbidity and mortality.

What is “linkage to care”?

The term “linkage to care” was first used in the context of HIV care to [refer](#) to an individual's first completed medical clinic visit after their HIV diagnosis. Completing the first visit was historically treated as a critical precursor to treatment and the establishment of a care continuum for HIV. This [care continuum](#) included many points of engagement in addition to a well-integrated benchmarking process for reporting and follow-up to all parties along the continuum. In the context of substance use disorders (SUDs), “linkage to care” has traditionally been defined as the activity preceding treatment. The [National Council for Mental Wellbeing](#) defines linkage to care as “connecting people at risk of overdose to evidence-based treatment, services and supports using a non-coercive warm hand-off that helps people navigate care systems and ensures people have an opportunity to participate in care when they are ready.” Similarly, this toolkit proposes expanding linkages to care by connecting people to a true care continuum, including social and healthcare services, community support, and safe spaces for ongoing care.

Because linkage to care models for people who use drugs vary based on setting and individual circumstance, this toolkit sets out to describe a core set of foundational principles, grounded in [harm reduction](#), that are applicable to linkage to care efforts. These principles embody a comprehensive approach to working with people who use drugs, and are defined as follows:

- Principle 1: Implementing harm reduction practices.
- Principle 2: Utilizing a trauma-informed approach.
- Principle 3: Addressing stigma.
- Principle 4: Accounting for social determinants of health.
- Principle 5: Integrating peers in linkages to comprehensive care.
- Principle 6: Providing intensive case management.
- Principle 7: Utilizing a drug user health framework.

Through these guiding principles, this toolkit outlines the specific practices that can support robust linkage to care efforts for people who use drugs. It describes where linkage to care activities occur and presents tools, cases, and circumstance-specific considerations to enhance these efforts. This toolkit's appendices focus on linkage to care efforts in specific settings and how to apply the guiding principles in each setting.

Linkage to care efforts include a broad range of practices and partners and should be implemented in a variety of settings to meet people who use drugs where they are. This means implementing linkage to care activities at locations such as:

- Healthcare settings (e.g., primary care offices, emergency department).
- Community-based organizations and social service agencies.
- Outpatient mental health and psychiatric settings.
- Syringe services programs.
- Opioid education and naloxone distribution programs.
- Homelessness services and housing programs.
- Mobile outreach programs.
- HIV/AIDS service and prevention programs.
- Correctional facilities.

This toolkit will illustrate how Maryland Department of Health's partners have implemented these guiding principles in a variety of settings. Providers and partners can use this toolkit to understand the importance of each of the above principles and how to incorporate them into their own linkage of care efforts. We hope that you find the information in this toolkit useful for your ongoing efforts to help people who use drugs access the care and social support services needed to prevent overdose and facilitate SUD-related recovery.

Introduction

Since 1999, approximately [932,000](#) people in the United States have died from a drug overdose. Over [91,000](#) people died from drug overdoses in 2020, and provisional data for 2021 reports [nearly 104,000](#) overdose deaths. Synthetic opioids, mainly [fentanyl](#), were involved in over 74% of the drug overdose deaths in 2020.



The COVID-19 pandemic has [exacerbated](#) the opioid crisis. Now, more than ever, people who use drugs face social isolation, loss of employment and economic opportunities, changes in public transportation access or provider availability, and concurrent mental health disorders—all of which contribute to increased overdose risk. Additionally, persistent barriers to care, stigma, bias against medications for opioid use disorder (MOUD), and punitive drug policy further affect overdose risk and directly contribute to overdose mortality. Given these barriers, healthcare providers and others who provide services to people who use drugs are uniquely positioned to [facilitate](#) practices to help people who use drugs to access services, **as the current care opportunity may be the only time that a person seeks care.**

For linkage to care efforts to be successful, providers should consider the whole person and their strengths, the context in which they live, and the barriers they face in accessing care, along with strategies to improve the quality of care they received. They must also meet people where they are in their life and in their [continuum of drug use](#) while maintaining as much flexibility as possible to support the individual. Providers should aim to incorporate trust-building and cultural humility throughout their experiences with people who use drugs to improve relationships and increase engagement in care. This increase in personal connection also offers an opportunity to [highlight effort with data](#) and to provide emotional support, or scaffolding, for [positive behavior changes](#). Using this tailored, person-centered approach maximizes the likelihood that people who use drugs will engage in high quality care.

The goal of improving linkages to comprehensive care for people who use drugs is to reduce overdose risk, increase access to care, and improve the timeliness of service delivery while increasing the effectiveness of prevention efforts for diseases, conditions, and disorders that share common risk factors, behaviors, and social determinants. This requires establishing collaborative partnerships across agencies and organizations that support people who use drugs and increasing the capacity for integrated, community-based services.

In 2020
91,000
People died from
drug overdoses

In 2021 nearly
104,000
People died from
drug overdoses

74%
Synthetic opioids
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Fentanyl were
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Principles Guiding Linkage to Care Efforts

Principle 1

Principle 1: Implementing Harm Reduction Practices

The National Harm Reduction Coalition [defines](#) harm reduction as “a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use... [it] is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.” Service providers whose work embodies harm reduction do not define people by their substance use and instead prioritize quality of life improvement over abstinence. This approach puts people first and encourages them to define their own goals and be the change agents in their own lives. A person’s drug use does not affect their access to harm reduction services, meaning services are

low-barrier and available to people regardless of current drug use.

A harm reduction approach also centers people who use drugs in shaping programs and policies that serve and impact them. An effective harm reduction program builds strong relationships with the community and constantly seeks input from people with lived experience; ideally, these programs are operated by people with lived experience. Programs incorporate practical education about risk reduction strategies and overdose prevention, but also address people’s health and social needs beyond those directly related to drug use. Further, harm reduction ensures that providers engage people who use drugs or have a history of drug use through shared decision-making and direct involvement to give these individuals a real voice in the creation of programs and policies designed to serve them.

Harm Reduction in the Field: Syringe Services Programs

[Syringe services programs](#) (SSPs) are community-based programs that distribute and collect hypodermic syringes for people who use drugs and provide these individuals with naloxone training and overdose education; SUD counseling, treatment, and recovery services; testing for HIV, hepatitis C, and STIs; reproductive health education and services; and linkages to a variety of healthcare and social services. Over [25 years of research](#) has demonstrated that SSPs are safe, reduce HIV and hepatitis C infections, and effectively provide naloxone and overdose education directly to people most likely to witness an overdose. SSPs in Maryland have incorporated [innovative approaches](#) to service delivery during the COVID-19 pandemic, including developing mobile units, prepackaged prevention kits, and mail-order naloxone.



Partnerships with SSPs can help improve linkages to care throughout a local jurisdiction. Strong referral networks, along with compassionate staff utilizing harm reduction and relationship-oriented approaches, support SSPs in providing increasing linkages to care for people at risk of overdose. In the first three months of 2022, Maryland SSPs provided [over 17,000 linkages to care](#) and over 50% of SSPs had 700 encounters each. Many [Maryland SSPs](#) also offer integrated care, including wound care, telehealth, and MOUD.

Maryland Trailblazer

Voices of Hope

Community-based organizations are important drivers of harm reduction activities across Maryland. The nonprofit [Voices of Hope](#) offers services for people who use drugs and people in recovery across Maryland, with a concentrated focus in Cecil and Harford counties. Many of the staff and volunteers are people with lived experience who can provide important perspectives for people who use drugs. The organization offers [Maryland Certified Peer Recovery Specialist](#) training, supervision, and internships to enhance the peer network in the state. In addition to this training program, Voices of Hope also provides trainings for peers working to support individuals in chaotic drug use, those preparing for change, those seeking treatment, and those in recovery. Staff and volunteers use motivational interviewing to engage with people who use drugs to help support and sustain change that is self-directed. Voices of Hope also conducts several [harm reduction activities](#), including:



- Naloxone distribution and training for organizations, families, and individuals.
- Compassionate wound care for wounds from injection drug use.
- Access to safe use supplies, connections to HIV and hepatitis C testing and treatment, and safer sex tools, education, and resources at their Little House of Harm Reduction.
- Syringe services, including cleanup and disposal.

Tools and Resources

- [Center for Harm Reduction Services](#) website from Maryland Department of Health.
- [“Harm Reduction Principles for Healthcare Settings”](#) article from *Harm Reduction Journal*.
- [Maryland Harm Reduction Training Institute](#) website.
- [Statewide Ethnographic Assessment of Drug Use and Services](#) website from University of Maryland Department of Anthropology and Johns Hopkins University.

Tool: Setting Specific Harm Reduction Practices Checklist



According to the National Harm Reduction Coalition, “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.”¹ By recognizing and using harm reduction, providers can better support people who use drugs with positive behavior change and improved quality of life. This tool is intended to introduce strategies that you can use to ensure your staff can promote harm reduction practices to clients and patients. **If your organization does not practice some of these strategies, consider developing a plan to implement these practices or requesting technical assistance from Alive! Maryland², the Maryland Harm Reduction Training Institute³, and the Center for Harm Reduction Services⁴.**

Two checklists are included for clinical and social services providers.

Clinical Provider Checklist

Clinical Provider	Yes	No
Are your services user friendly and responsive to patients’ needs?		
Do you encourage clients to be in control of their care and decisions?		
Does your team tailor message and intervention for each client and maximize treatment options for each client served?		
Do you “penalize” clients for making the decision to continue to use drugs or engage in high-risk activities?		
Do you provide wound care?		
Do you provide supplies for safer use (e.g., new syringes, fentanyl test strips)?		
Do you provide education on syringe service programs and discuss safer injection strategies?		
Do you provide opioid overdose education and naloxone?		
Do you offer testing for hepatitis, HIV, STD, and TB?		
Do you have a DATA-waivered provider in your organization and provide medications for opioid use disorder for individuals interested in treatment?		
Do you offer all FDA-approved medications for opioid use disorder?		

¹ National Harm Reduction Coalition. “Principles of Harm Reduction.” Available at:

<https://harmreduction.org/about-us/principles-of-harm-reduction>. Accessed 10-4-2022.

² Alive! Maryland. “Point-to-Point Capacity Building Assistance.” Available at: <https://alivemaryland.org/cba>.

Accessed 10-4-2022.

³ Maryland Harm Reduction Training Institute. “Home.” Available at: <https://www.mahrti.org>. Accessed 10-4-2022.

⁴ Maryland Department of Health Prevention and Health Promotion Administration. “Center for Harm Reduction Services.” Available at: <https://health.maryland.gov/phpa/Pages/accessharmreduction.aspx>. Accessed 10-4-2022.

Social Services Provider Checklist

Social Services Provider	Yes	No
Do you simplify the way our services are designed for adults in poverty overload and deplete their self-regulation skills?		
Do you focus on ways to relieve stressors by addressing basic needs first		
Do you provide overdose education and naloxone?		
Do you support staff professional development and advanced training in motivational communication or participant engagement? ¹		
Do you incorporate tools and techniques that help people take greater advantage of available services and build core capabilities?		
Are you mindful of the interactions between caseworkers and those being served: less stigma and more coaching, mutual respect		

¹ Camden Coalition. "The COACH framework." Available at: <https://camdenhealth.org/care-interventions/the-coach-model>. Accessed 10-4-2022.

Tool: 10 Things People Who Use Drugs Would like Practitioners to Know



This fact sheet is adapted from *Mothering and Opioids*,¹ specifically with Maryland Behavioral Health Administration's Stigma Campaign² and the Statewide Ethnographic Assessment of Drug Use and Services report.³

“We want to succeed. Just because I am still using doesn't make me a bad person.”

“Don't treat us as objects.”

“Talk to me. Ask questions, like, “What do you need to support your recovery journey? How can I support you to being well today?””

“Listen in an open-minded way and be curious about what might work for me. What I want is important. Don't just judge and lecture me.”

“Language matters—Say things like, “I have seen this help others, maybe this will work for you” not, “you should.””

“Don't shame me or I won't come back.”

“Don't just throw me a sheet of resources and wish me well. Show empathy, not pity. Introduce me to someone who can help me navigate this journey.”

“Don't treat us all the same. Everyone's journey to recovery is different and unique.”

“The system is not set up to hear us. Provide a place to give feedback.”

“Don't judge. Instead, care.”

¹ Centre of Excellent for Women's Health. “Mothering and Opioids—Addressing Stigma, Acting Collaboratively.” Available at https://cewh.ca/wp-content/uploads/2022/01/CEWH-03-MO-Toolkit_WEB_Update-F-1.pdf. Accessed 10-4-2022.

² Before It's Too Late. “Stigma of Addiction Realized.” Available at <https://beforeitstoolate.maryland.gov/stigma>. Accessed 10-4-2022.

³ University of Maryland Department of Anthropology. “Statewide Ethnographic Assessment of Drug Use and Services.” Available at <https://anth.umd.edu/project/statewide-ethnographic-assessment-drug-use-and-services-%28seads%29>. Accessed 10-4-2022.

Principle

2

Principle 2: Utilizing a trauma-informed approach

Adverse childhood experiences (ACEs)—e.g., neglect or abuse—and trauma [increase](#) an individual's risk of developing negative health outcomes, including [SUDs](#). According to [CDC](#), 61% of adults across 25 states were found to experience at least one type of ACE, while over 10% reported experiencing four or more types of ACE. One study [indicated](#) that people with a 6+ ACEs score were 46 times more likely to use intravenous drugs relative to people with 0 ACEs. In Maryland, the 2018 Behavioral Risk Factor Surveillance System data indicated that [62% of adults](#) experienced at least one ACE. Acknowledging this, any effort to assist people who use drugs, including linkages to care, must integrate a trauma-informed approach.

The 1988 CDC-Kaiser Permanente [adverse childhood experiences study](#) set the stage for incorporating ACEs assessment across a wide range of services and agencies. The study created an [original list of ACEs](#), which has [expanded](#) in the last 10 years. Understanding the outcomes of the ACE study and the types of ACEs is critical to developing a trauma-informed approach within any organization. ACEs can have lasting effects, increasing the risk of negative health outcomes later in life. Figure 1 highlights how ACEs influence individuals through the lifespan.

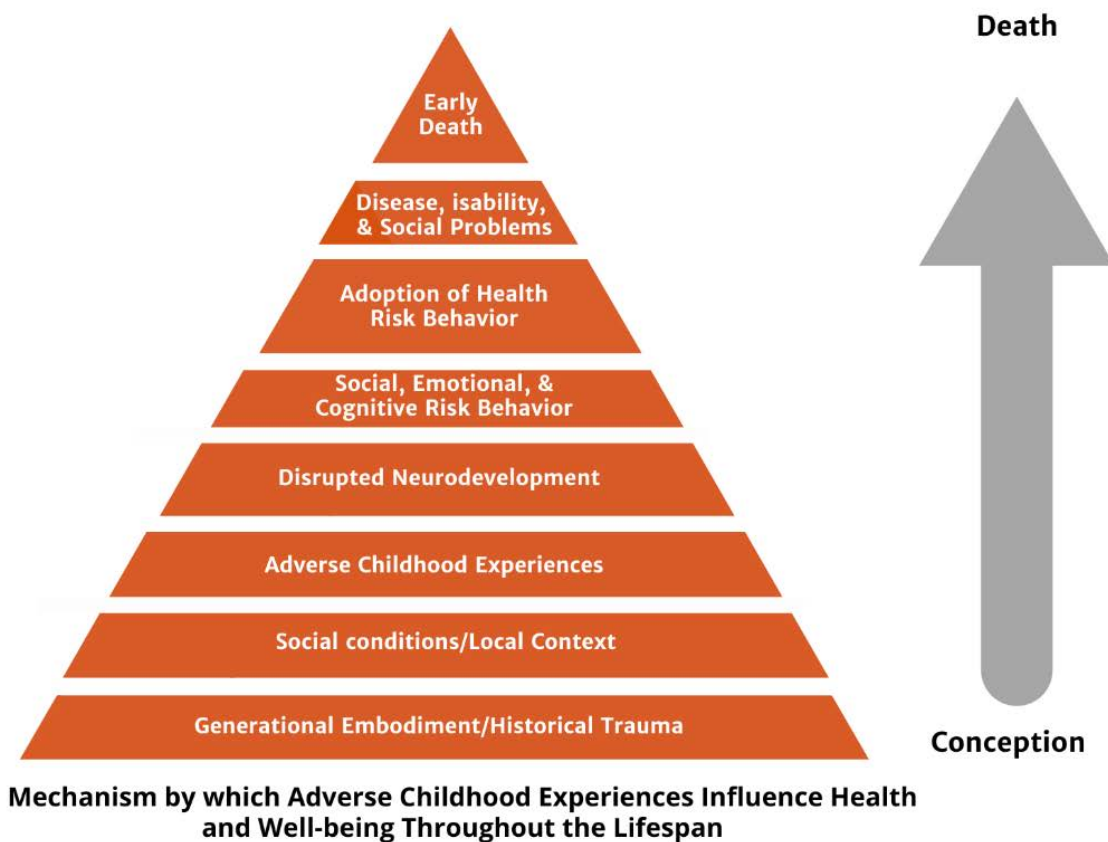


Figure 1: ACEs' influence across the lifespan. Adapted from: [About the CDC-Kaiser ACE Study](#).

CDC's [Office of Public Health Preparedness and Response](#) adopted the Substance Abuse and Mental Health Services Administration's (SAMHSA) proposed [principles](#) for being trauma-informed, which are listed in Table 1.

Table 1: SAMHSA Principles for Being Trauma-Informed. (Adapted from Indiana Family and Social Services Administration’s [Trauma-Informed, Recovery-Oriented Systems of Care](#))

Principle	Definition	Examples in Practice
<i>Safety</i>	Ensuring physical and emotional safety among individuals and staff.	• Understand that safety as defined by individuals receiving services is a high priority of the organization. • Respect privacy in all interactions.
<i>Trustworthiness and Transparency</i>	Conducting operations and making decisions with transparency and the goal of building and maintaining trust with individuals, family members, and staff.	• Provide clear information about services. • Ensure informed consent. • Schedule appointments consistently.
<i>Peer Support and Mutual Aid</i>	Promoting recovery and healing by valuing peers or individuals with trauma histories and applying their lived experience.	• Facilitate group and partner interactions for sharing recovery and healing from lived experiences. • Include peer supporters in health teams.
<i>Collaboration and Mutuality</i>	Making decisions in partnership with individuals and sharing power between individuals and provider.	• Give individuals a significant role in planning and evaluating services.
<i>Empowerment, Voice, and Choice</i>	Individuals retain choice and control during decision-making and individual empowerment, with emphasis on skill building.	• Create an atmosphere that allows individuals to feel validated and affirmed with each contact. • Provide clear and appropriate messages about individuals’ rights, responsibilities, and service options.
<i>Cultural, Historical, and Gender Issues</i>	The organization deliberately moves past cultural stereotypes and biases and incorporates policies, protocols and processes that are responsive to the racial, ethnic, cultural, and gender needs of individuals served.	• Ensure access to services that address the specific needs of individuals from diverse cultural backgrounds. • View every policy, practice, procedure, and interaction through a cultural and linguistic competence lens.

Integrating these principles into linkage to care efforts in any setting can ensure that these efforts are mindful of trauma and will not cause additional trauma for the people the efforts are intended to serve.

Translating principles into actions that an organization can disseminate, sustainably adopt, and monitor is a complex process. SAMHSA offers detailed [implementation guidance](#) across the 10 domains of governance and leadership; policy; physical environment; engagement and involvement; cross-sector collaboration; screening, assessment and treatment services; training and workforce development; progress monitoring and quality assurance; financing; and evaluation.

Special Considerations

Intergenerational Trauma and Ongoing Structural Racism and Oppression

A growing area of research and discussion also [includes](#) intergenerational trauma and the effects of historical and cultural traumas on survivors and their children. Intergenerational trauma is often the result of structural racism and oppression. In addition to the intergenerational lens, it is important to consider the role that ongoing structural racism plays in driving many of the traumatic events that people from gender, racial and ethnic, and other minority groups face today. Intergenerational trauma can [impact](#) health and wellbeing, including mental and behavioral health and actively [practicing anti-racism](#) work can create opportunities for healthy outcomes. While in some sense it is easier to define

high-profile traumatic events, to be trauma-informed it is equally important to validate these other forms of trauma and incorporate information about the mechanisms for how they are propagated into your organization's concrete actions.

The Role of Resilience and Recovery-Oriented Care

By practicing trauma-informed care, providers can foster resilience in individuals and communities and help them more successfully maintain recovery. Increasing confidence in sustaining behavior change, [building core capabilities](#), and establishing cultural and community connections can support building resilience among adults. Recovery-oriented systems of care provide comprehensive services to support long-term recovery and build on the strengths and resilience of individuals, families, and communities.

The Trauma Recovery Model

Recovering from trauma is a complex, lifelong process that can require numerous providers, relationships, and other tools and resources to help an individual heal. [One enduring model](#) for recovering and/or rehabilitating from trauma, proposed by Dr. Judith Herman, includes the following three stages, which are important to keep in mind when developing a trauma-informed approach to linkages to care:

- **Stage 1—Safety:** An individual can re-establish a sense of emotional safety and bodily integrity.
- **Stage 2—Remembrance and mourning:** The focus is on the retelling and mourning of traumatic experiences.
- **Stage 3—Integration:** Work is done to re-establish relationships and interact and integrate with their community and society.

It is important to be thoughtful about how much you will incorporate these concepts into your practice processes and be clear with staff about how these concepts are deeply intertwined.

Maryland Trailblazer

Justice and Recovery Advocates, Inc.

[Justice and Recovery Advocates, Inc.](#) is a nonprofit in Maryland that supports people who are incarcerated, were incarcerated, or were otherwise institutionalized and those that love them, focused on mental health and other SUD issues. The organization operates statewide and provides a variety of trauma-informed services to those who seek them out. The nonprofit offers support groups and wellness programs to those who are interested in finding community or learning how to support themselves or a loved one through health and wellness. The group offers many resources and educational opportunities related to SUD, incarcerations, the criminal justice system, and naloxone training for a range of partners, such as health providers, legal professionals, family assistance providers, and family therapists.



A large component of the provided services are reentry-focused, which the nonprofit has continued despite the COVID-19 pandemic. These services support returning citizens by coordinating between a case manager and the individual or family for a positive transition. Services support the whole individual, including:

- Substance use and/or mental health treatment.
- Referrals to other provider care.
- Assistance with social services and benefits applications and resources.
- Housing assistance.

- Harm reduction programming.
- Peer support.

Tools and Resources

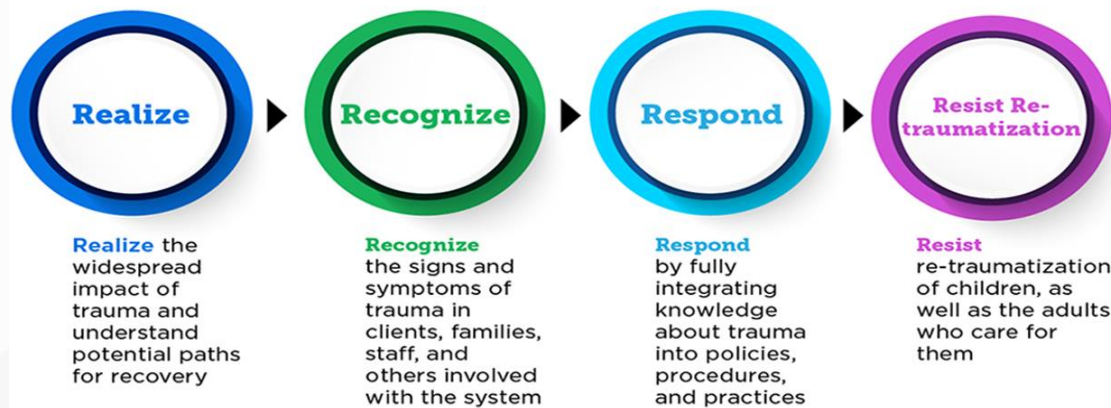
- [ACE Interface Trainings](#) website from the Family Tree and Maryland Essentials for Childhood.
- [“At the Front Lines in Tennessee: Rural Clinic Offers Trauma-Informed Treatment for Substance Use Disorder”](#) article from the Center for Health Care Strategies.
- [Creating Trauma-Informed Systems](#) website from the National Child Traumatic Stress Network.
- [Fostering Resilience and Recovery: A Change Package](#) website from the National Council for Mental Wellbeing.
- [Sample Questions to Consider when Implementing a Trauma-Informed Approach](#), page 14 of the report “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach.”
- [Trauma-informed Recovery-oriented Systems of Care](#) toolkit from the National Council for Mental Wellbeing and the Indiana Family and Social Service Administration.
- [“The Trauma Recovery Model”](#) article from *Psychiatry and Clinical Neurosciences*.

Tool: Discussion Questions for Assessing Trauma-Informed Care Practices



Originally developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), the “Four R’s” for a trauma-informed approach are displayed below.¹

The Four Rs of Trauma-Informed Care



Source: [How to Implement Trauma-informed Care to Build Resilience to Childhood Trauma](#).

Assess if your clinic or office is utilizing trauma-informed practices and ensure all team members who interact with patients or clients are included. The following organizational and position assessments provide opportunity to consider the status of being trauma-informed and can be used on a regular basis to keep track of progress.

Organizational Assessment

1. Do all people at all levels of your organization or system have a basic realization about trauma and understand how trauma can affect individuals, families, groups, organizations, and communities?
2. Do you display positive and welcoming signage with a friendly tone when people access services, with an integrated and consistent response from all team members, from front desk staff to direct care workers?
3. Do you provide a comforting and welcoming physical environment?
4. Do you provide training to clinical and non-clinical staff members on recognizing the signs of trauma in clients, families, staff, and others?
5. Do you review policy and procedures to reduce the risk of re-traumatization of clients with trauma histories?

¹ Substance Abuse and Mental Health Services Administration. “SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.” Available at: <https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884>. Accessed 10-4-2022.

Position Assessment

(For all groups of individuals or teams who interact with patients/clients)

Complete for each position that interacts with patient/client (i.e., front office, medical assistant, provider, social worker).	
<i>(Fill in name of position)</i>	Yes/No
1. Do you and your team use strength-based, person-first language?	
2. Do you recognize that some people will need more or different support than others?	
3. Do you evaluate yourself and recognize what you carry into the interaction (e.g., your story, family experiences, race, religion, beliefs about substance use)?	
4. Do you have trained team members who effectively engage in therapeutic conversations with people, including opening conversations, de-escalation, or supporting clients when interacting with individuals who are not trauma-informed?	
5. Do you empower participants and clients to set boundaries and determine the pace of physical assessments in the clinical setting?	
6. Do you provide active and warm handoffs to additional services that may be required or requested?	

For additional details on trauma-informed care and how to incorporate these strategies into your clinic or office, refer to SAMHSA's Treatment Improvement Protocol 57.¹

¹ SAMHSA. "Treatment Improvement Protocol 57: Trauma-Informed Care in Behavioral Health Services." Available at: <https://www.samhsa.gov/resource/ebp/tip-57-trauma-informed-care-behavioral-health-services>. Accessed 10-4-2022.

Principle

3

Principle 3: Addressing Stigma

Stigma can be [defined](#) as “a set of negative and often unfair beliefs that a society or group of people have about something.” Additional discussions [reinforce](#) the dynamic nature of the process/es of stigmatization through a combination of labelling, stereotyping, separation, status loss, and discrimination. To understand stigma, and the extent to which individuals and communities successfully attribute and accept it, we need to understand the unequal (social) power relations that underpin it. Most talk around drug use stigma focuses on harmful language.

However, stigma comes in various forms that influence our interventions, policies, and understanding of issues related to the health of people who use drugs. Understanding the different types of stigma and how each influences our approach to overdose and drug user health can allow us to understand why stigma remains a persistent barrier to care and service access.

Figure 2 outlines the various types of stigma, from those an individual may feel about themselves to the institutional stigma that has permeated society.



Figure 2: Types and definitions of stigma related to people who use drugs.
(Adapted from [Overcoming Stigma](#), National Association on Mental Illness.)

It is important to understand the stages of stigma and how they feed into each other in ways that add more burden to people who use drugs:

- The dominant group uses stigmatizing labels to identify people who use drugs to create division. These labels sustain this division and reinforce our perceptions of issues impacting people who use drugs and drug addiction.
- After labeling, the dominant group frames people who use drugs as deviant “others.”
- Organizations develop policies, such as drug screening in workplaces, removal from SUD treatment for relapse, or not being able to access housing or higher education, which further ostracize people who use drugs. The underlying message is that there is something “wrong” with people who use drugs, and they need to be quarantined.

- Once someone has had a stigmatizing label applied to them, they lose any social status that they previously held.
- Finally, states pass laws that further stigmatize people who use drugs by applying the label of “criminal” to an already stigmatized and vulnerable population. If a person gets a felony charge related to drug use/possession, they become a second-class citizen due to the collateral consequences they receive from their felony status (i.e., they are denied their right to vote or own a firearm, and they can be denied opportunities for employment, college, and military service).

Providing services and resources in a non-judgmental, non-coercive way is critical, as stigma is a [prevalent problem](#) facing people who use drugs and can keep them from accessing care. [According to](#) National Institute for Drug Abuse Director Dr. Nora Volkow:

“

Even when treatments and other supports are available, people with addiction may not seek them, fearing the judgments of those around them and the discrimination they routinely experience in the health care system. Patients are often hesitant to disclose their substance use to their physicians. This contributes to the tragic reality that fewer than 13% of people with an illicit drug use disorder received any treatment for their addiction in 2019 and just 18% of people with [OUD] received one of the three safe, effective, and potentially lifesaving medications that could facilitate their recovery. The proportion of people with alcohol addiction who received medications is even lower: 3%.

”

When discussing and addressing stigma within linkages to care, it is important to recognize the prevalence of [intervention stigma](#). People who use drugs experience intervention stigma when they receive a medical treatment such as MOUD. While MOUD is considered the gold standard for treating OUD, uptake remains low, often due to institutional, association, and internalized stigma. [Intervention stigma around MOUD](#) can stem from providers mistakenly viewing MOUD as “one drug replacing another,” the treatment option only being a temporary measure while people who use drugs find a “better treatment” option, mistrust of MOUD based on past over-prescription issues, and a general lack of understanding of MOUD treatment among providers.

[Language](#) can greatly influence people’s perceptions about a topic. Person-first language has been used in various spaces to encourage a focus on the person rather than their condition or situation (such as with “[people with disabilities](#)” instead of “disabled people”). Providers can [apply](#) the same principles to change their language for people with SUD or people who use drugs.

- People with SUDs are [viewed](#) more negatively than those with physical or psychiatric disabilities, even among highly trained SUD and mental health clinicians, adversely impacting their care options and opportunities. These negative views have been [found](#) to worsen individual’s quality of care and resulting treatment outcomes.

- A public perception study [noted](#) that the term “abuse” was found to have a high association with negative judgment and punishment in the content of drug use.

Maryland Trailblazer

Maryland Department of Health Center for Harm Reduction Services

The Maryland Department of Health’s [Center for Harm Reduction Services](#) created the [Regrounding Our Response](#) program with community-based education to reduce stigma and build support for a more compassionate, evidence-based approach to the overdose crisis. Regrounding Our Response focuses on educating community leaders, healthcare and social service providers, and other key partners involved in overdose response efforts. Individuals can attend one or more interactive sessions on these topics to learn how to support their communities. Topics include:



- Social determinants of health.
- Adverse childhood experiences.
- Stages of change.
- MOUD as overdose prevention.
- The drug user health framework.

Further, the center provides funding and technical assistance to local health departments and community-based organizations that are interested in implementing or expanding services that serve people who use drugs.

Tools and Resources

- [“Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change”](#) report from the National Academies of Sciences, Engineering, and Medicine.
- [Mothering and Opioids: Addressing Stigma – Acting Collaboratively](#) toolkit from the Centre of Excellence for Women’s Health.
- [“Provider Perspective: Malik Burnett, MD, MBA, MPH”](#) interview from Alive! Maryland.
- [“Respect to Connect: Undoing Stigma”](#) factsheet from National Harm Reduction Coalition.
- [“Words Matter”](#) factsheet from Maryland Department of Health.

Tool: Discussion Questions for Understanding Stigma and Strategies for Challenging Stigma



As discussed in this toolkit, there are internalized, individual, association, and institutional types of stigma. This discussion guide explores how individual and institutional stigma can challenge a person's goals or expectations for their recovery or care. Organizations can use the guide to have open discussions about stigma in the workplace.

Leadership Questions

1. What is the frequency by which staff are educated on countering inaccurate stereotypes or myths about drug use and overdose? Which trainings or approaches have been well-received, and why?



2. In what ways do you ensure confidential participation and/or access to voluntary educational training sessions related to drug use?



3. Have your workplace policies been reviewed¹ for possible stigma and discrimination against individuals with substance use disorder or in recovery? If not, could you convene a group to develop a plan to update policies accordingly? What may be standing in the way of updating policies?



4. Do you provide all staff with materials and training to ensure no one appears to be singled out? Do you provide substance use resources alongside other staff resources?



5. If someone expresses stigmatizing behavior, how do you engage with them to discuss the behavior and move toward change?



6. Let's talk about your policies that provide comprehensive coverage for substance use disorder. How are these policies currently being offered (i.e., offered to all staff as opposed to opting in)?



7. What type of opportunities do you provide for staff to build or participate in support groups?



¹ Canadian Centre on Substance Use and Addiction. "Checklist for Workplace Policies on Substance Use Stigma." Available at: <https://www.ccsa.ca/sites/default/files/2021-08/CCSA-Checklist-Workplace-Policies-Substance-Use-Stigma-2021-en.pdf>. Accessed 10-4-2022.

Individual Discussion Questions

1. What are your own potential biases, your organization's biases, and ways that you may internally or externally shame people who use drugs or their families?



2. What are some examples of stigmatizing language you've heard or have used about drug use or addiction? What do you think you can do to promote non-stigmatizing language?



3. Why is there a difference between the societal response to a pandemic and the societal response to overdose? What role does stigma play in shaping the response?



4. Do you have stories of recovery to share, and do you feel comfortable sharing them in your organization? They are powerful. If you do not feel comfortable, what are the barriers to sharing?



5. Are any of these stories related to adverse childhood experiences, how common they are, and their relationship to addiction?



6. What could your organization do better to support both staff members and patients and clients whom you serve with substance use disorder or who use drugs?



7. In what ways can you or your organization support access to evidence-based treatment? Sometimes the opportunity to help someone find help is brief. Be ready. Where can you go to ask for help or share resources?



Principle

4

Principle 4: Accounting for Social Determinants of Health

The World Health Organization defines [social determinants of health](#) (SDOH) as “...the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” An individual’s circumstances can be shaped by resource distribution—such as access to education, employment, income, and nutrition—at varying levels of government and organization. Addressing SDOH is essential to reducing health disparities and improving linkages to comprehensive care for all Marylanders.

All people experience sociocultural complexity, and people who use drugs are no exception. Realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect people’s vulnerability to and capacity for effectively dealing with a drug-related harm. Therefore, while it is important to connect people who use drugs to treatment, when appropriate, it’s also critical to connect them to social services and support to improve their whole-person health. Key terms are defined in Table 2 and described via illustration in Figure 3.

Table 2: Definition of terms related to justice and equity.

Inequality	Unequal access to opportunities.
Equality	Evenly distributed tools and assistance.
Equity	Custom tools that identify and address inequality.
Justice	Fixing the system to offer equal access to both tools and opportunities.
Health disparities	Differences in health status among distinct segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities
Health inequities	Disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity.

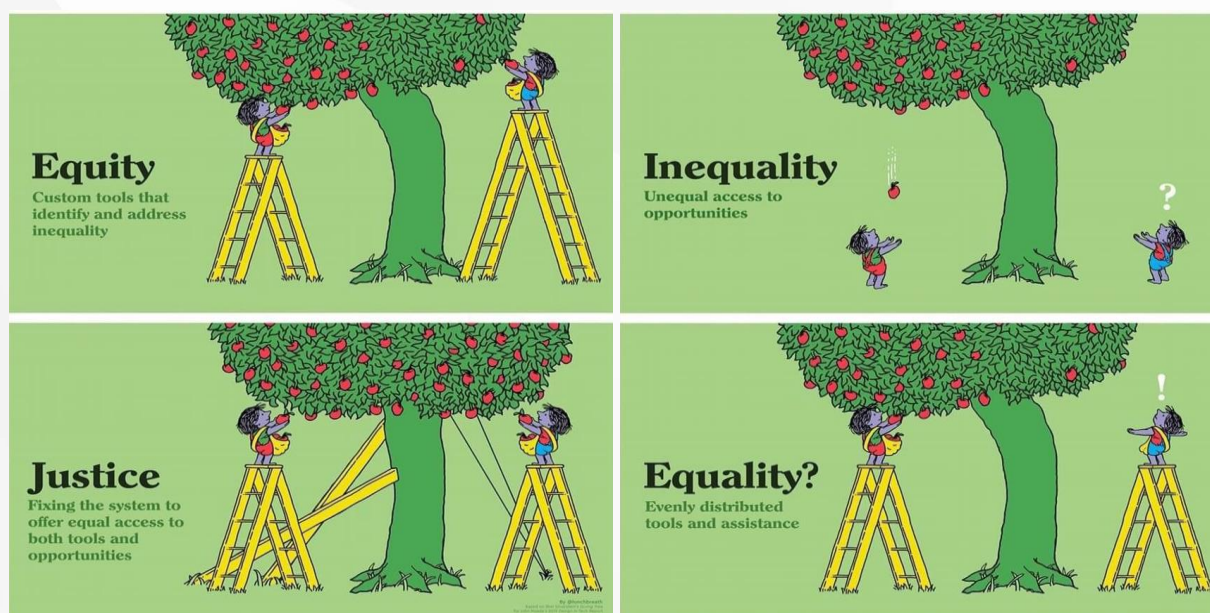


Figure 3: Shel Silverstein’s *The Giving Tree* as examples of equity, inequality, justice, and equality. Source: [Defining Diversity, Equity, and Inclusion](#), American University.

Pursuing equality causes an individual or policy to ensure the equal distribution of resources, but pursuing justice causes an individual or policy to address biases within systems to ensure equal distribution of resources. Justice thus translates into equal access to opportunities. To improve the health of all, reducing or eliminating inequities between groups must be a priority, and establishing

justice-informed policies can help realize these goals. Additionally, increasing [social cohesion](#), by strengthening relationships and a sense of solidarity among members of a community, can improve overall health and serve as a protective factor to reduce the impacts of inequities.

A socioecological model can explain how interactions between an individual, groups, and the community—influenced by physical, social, and political environments—can affect health. As Figure 4 shows, SDOH are important factors at every level of the overdose crisis. The socioecological model suggests that to reduce substance-related morbidity and mortality, **it is necessary to act at multiple levels of the model**. The model also reveals root causes of health disparities that can impede overdose response strategies, as no one factor in any level of the model leads someone to use or misuse drugs.

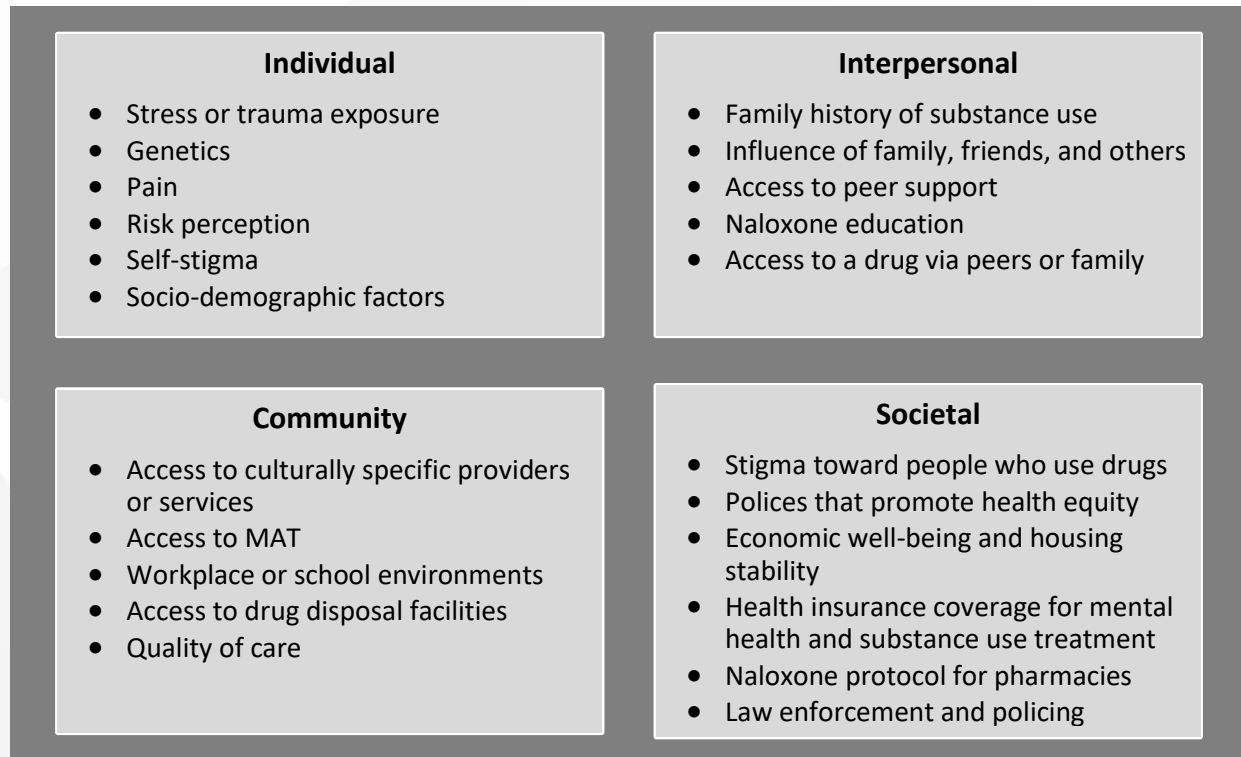


Figure 4: Socioecological model levels and examples of social determinants of health. Adapted from [The opioid crisis: a contextual, social-ecological framework](#), Health Research Policy and Systems.

Interventions to address the policies and systems contributing to the overdose crisis are numerous and should be considered part of an organization’s efforts to facilitate change. Some interventions proposed by the [Brookings Institution](#) and [CDC](#) include:

- Use Medicaid to reimburse supportive housing services shown to improve health.
- Implement targeted naloxone distribution so that naloxone ends up in the hands of people most likely to witness an overdose.
- Eliminate prior authorization requirements for and expand access to MOUD.
- Initiate MOUD in emergency departments.
- Implement SSPs to provide access to sterile equipment, tools for preventing and reversing opioid overdose, infectious disease testing and treatment, and social and medical services.

Incarceration and Overdose

Mass incarceration has dramatically [impacted](#) the landscape of the overdose crisis. Criminalizing people who use drugs has been an international policy approach for decades, largely stemming from [the war on drugs](#). Because of policies to arrest and incarcerate people who use drugs, and the common practice of

giving harsher sentences for certain drugs which disproportionately affect people of color, disparities and community impacts of mass incarceration continue to escalate. Some jurisdictions have already started [providing](#) access to support services rather than arresting people who use drugs, but greater adoption of these practices is needed.

Those who leave an incarcerated setting are faced with layers of challenges. Often, there is [stigma](#) against people who have been incarcerated, as well as collateral consequences rooted in policies that isolate individuals and prevent them from reengaging with the community. Formerly-incarcerated people can also have [diminished tolerance](#) to opioids while incarcerated without access to MOUD, [significantly increasing their risks](#) of drug overdose following release. These challenges are harmful and greatly increase overdose risk, so re-entry services should support the whole person and community connections. Without recognizing the full drug-use continuum and the role of SDOH, the current responses to drug overdose will continue to aggravate the problem they are trying to solve.

Maryland Trailblazer

Calvert County Health Department Syringe Service Program

[Calvert County Health Department's](#) services include harm reduction activities for people who use drugs and people with SUD. Along with the robust general services of the [Calvert County Local Behavioral Health Authority](#) and [access to treatment](#), the health department also boasts an SSP that provides additional services to support people who use drugs in their substance use journey. These services include [syringe disposal and clean up](#), and the county is in the top five counties for collecting syringes. Further, the county supports state care coordination for those who need additional assistance, and provides overdose and substance use prevention education.



The county also is involved in a variety of community-based programming efforts to enhance its citizens' lives. First are Health and Wellness pop-up tents, where a nurse practitioner and harm reduction staff provide physical and behavioral health connections. Additionally, quarterly meetings provide an opportunity to brainstorm and develop programming, including [campaign videos](#) to outline important focuses in the county. The county is also involved in [Stepping Up](#), the national movement to reduce the number of people with mental illnesses in incarceration, and has [identified](#) key areas and activities that can help residents with mental illnesses better access treatment and other services.

Tools and Resources

- [“A Conceptual Framework for Action on the Social Determinants of Health”](#) report from the World Health Organization.
- [“Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity”](#) issue brief from Kaiser Family Foundation.
- [“Nonviolent Drug Convictions: Stakeholders' Views on Potential Actions to Address Collateral Consequences”](#) report from the U.S. Government Accountability Office.
- [Protocol for Responding and Assessing Patients' Assets, Risks, and Experiences: Implementation and Action](#) toolkit from National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, and Oregon Primary Care Association.
- [“Situating the Continuum of Overdose Risk in the Social Determinants of Health: A New Conceptual Framework”](#) article published in *The Milbank Quarterly*.
- [Social \(In\)Justice and Mental Health](#) book edited by Ruth S. Shim and Sarah Vinson.

Principle

5

Principle 5: Integrating Peers in Linkages to Comprehensive Care

Peer recovery specialists (PRSs) can provide a range of services for people who use drugs across the continuum of care. PRSs provide non-clinical assistance and support long-term recovery. The [benefits](#) of peer support include lived experience in recovery, help initiating and maintaining recovery, and an enhanced quality of personal and family life in long-term recovery. Peer support is directly connected to harm reduction practices as it affirms people who use drugs themselves as the primary agents of reducing the harms of their drug use and seeks to empower people who use drugs to share information and support each other in strategies that meet their actual conditions of use.

Peer support provides person-centered and strength-based support to help people access evidence-based treatment, support positive behavior change, and begin and sustain long-term recovery. MDH's Behavioral Health Administration supports a [certified PRS program](#). Marylanders can apply to support people who use drugs through their lived experience in the state, providing a common ground to build a trusting relationship as well as job opportunities and career paths for people in recovery. **Figure 5** outlines the types of support PRSs can provide.

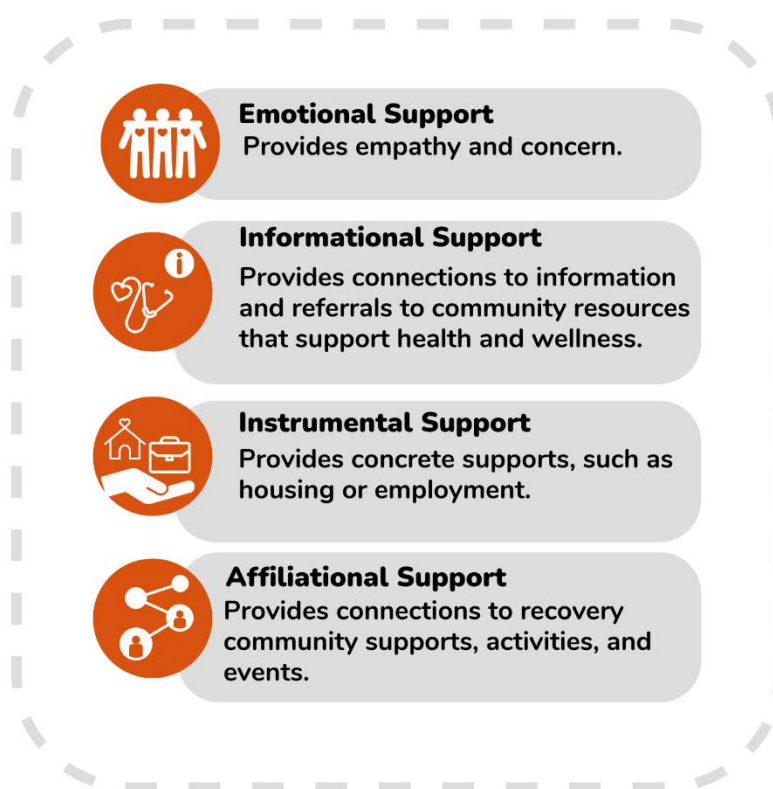


Figure 5: Types and definitions of support PRS can provide. Adapted from [Peers Supporting Recovery from Substance Use Disorder](#), SAMHSA.

Peers support people with individualized recovery planning, which often builds on an individual's strengths, needs, and recovery goals. According to [SAMHSA](#), people receiving peer recovery support may experience:

- Decreased criminal justice involvement.

- Improved relationships with treatment providers.
- Increased treatment retention.
- Decreased emergency service utilization.
- Reduced rates of resumed substance use.
- Reduced rehospitalization rates.
- Increased satisfaction with the overall treatment experience.
- Improved access to social supports.
- Reduced substance use.
- Greater housing stability.

Incorporating peers into linkages to care can improve engagement in needed healthcare and social services. People who use drugs have [expressed](#) that building trust with a provider is meaningful to their experience and outcomes. Increased long-term trust and [active referral interventions](#) between a person who uses drugs and a peer or services provider can [improve outcomes](#). People who use drugs may prefer working with someone with a shared lived experience, and both peers and people who use drugs could [have](#) mutual benefits. [Key PRS activities](#) include:

- Advocating for people in recovery.
- Sharing resources and building skills.
- Building community and relationships.
- Leading recovery groups.
- Mentoring and setting goals.
- Providing services and/or training.
- Supervising other PRSs.
- Developing resources.
- Administering programs or agencies.
- Educating the public and policymakers.

Through [core competencies](#) and educational practices, peers can use their lived experience and professional skills to engage with people who use drugs, their friends, and their families to connect through shared experiences. This can provide an opportunity to build a supportive and robust relationship.

Maryland Trailblazer

Howard County Naloxone Leave Behind Program

Naloxone can [reverse](#) the effects of opioids. It comes in various forms, including nasal and intravenous, and can be a critical tool in keeping an overdosing person alive. Effectively distributing and educating people on the lifesaving effects of naloxone can [build](#) the infrastructure to reverse potentially fatal overdoses.

In Howard County, an emergency medical services (EMS)-based program will [distribute](#) naloxone to someone who has experienced an overdose, their family, their friends, and others who may be in close contact with them. Following a reversed overdose, either by EMS or by someone else, EMS personnel will leave behind a kit including naloxone whether the individual accepts transport to medical care. EMS will also attempt to obtain the best follow-up phone number for future contact by Howard County Health Department as part of their collaborative urgent follow-up program. The health department will attempt to contact a person who experienced an overdose within one business day and may conduct a home inspection that could include: naloxone education, treatment referrals, information about SSPs, and other services.



Tools and Resources

- [Maryland Department of Health's Certified Peer Recovery Specialist Program](#) information on MDH's CPRS program.
- ["Recommendations for integrating peer mentors in hospital-based addiction care"](#) article published in *Substance Abuse*.
- ["Universal screening for substance use by Peer Support Specialists in the Emergency Department is a pathway to buprenorphine treatment"](#) article published in *Addictive Behaviors Reports*.
- [Peer Support Toolkit](#) from City of Philadelphia Department of Behavioral Health and Intellectual Disabilities Services.
- ["Peer navigation and take-home naloxone for opioid overdose emergency department patients: Preliminary patient outcomes"](#) article published in *Journal of Substance Abuse Treatment*.

Principle

6

Principle 6: Providing Intensive Case Management

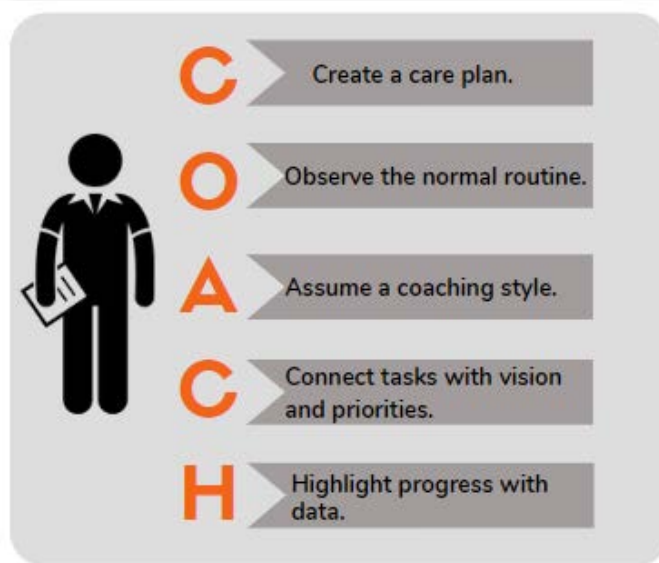
People who use drugs may have complex needs and experience complex barriers to receiving care and support, such as SUD co-occurrence with severe mental illness. As a result, some people who use drugs may need [intensive case management](#) because they are at a higher risk of overdose and other negative health outcomes.

[Intensive case management](#) can be extremely helpful to help manage multiple points of contact with health and social services systems by consolidating all services to a single point of contact and reducing the number of agencies and referrals an individual interacts with. Increasing the number of connections between providers and people who use drugs can increase the likelihood that individuals will be [connected](#) to services that can reduce their risk of overdose, such as [MOUD](#).

Intensive case management incorporates a variety of person-centered practices, including:

- Implementing smaller caseloads (e.g., 15 to 25 individuals per provider).
- Meeting people where they are by using direct contact, accessing multiple spaces, and not time-limiting services.
- Supporting a harm reduction approach to reducing drug use rather than requiring full abstinence from substances.
- Encouraging participants to drive their goals, plans, and relationships through strengths-based relationship building.

An example of intensive case management in practice is the [COACH Model](#) from the Camden Coalition of Healthcare Providers in New Jersey. COACH is an acronym that [describes care teams](#) with a shared vision to:



The COACH model focuses on authentic and healing relationships between providers and patients with complex health and social needs, empowering them to be the drivers of their health and wellbeing.

Maryland Trailblazer

Charm City Care Connection

Local support and connection to services can enhance a person's access to resources. [Charm City Care Connection](#) in Baltimore employs case management to robustly support people who use drugs and people with SUD. Through dignity, justice, and respect, the team has been providing support since 2009, and began offering harm reduction services in 2019. Individuals can access their [services](#), including case management support, via their drop-in service center or their mobile outreach. Through their case management, persons accessing services can receive:



- Connection to SUD treatment.
- Connection to mental health treatment.
- Application support for benefits or housing.
- Transportation support.
- Help obtaining personal documents (e.g., birth certificates, IDs).
- Budget management.

The organization considers the whole person and activities that may impact sustainable recovery efforts, and these services ensure that a person is not just referred to or put into treatment.

Tools and Resources

- [Camden Coalition Current Course Offerings](#) website.
- [Create a Backwards Plan: Instructional Guide and Domain Cards](#) from Camden Coalition.
- [“Comprehensive Case Management for Substance Abuse Treatment: Treatment Improvement Protocol \(TIP\) Series 27”](#) report from SAMHSA.
- [“Intensive Case Management for Addiction to promote engagement with care of people with severe mental and substance use disorders: an observational study”](#) article published in *Substance Abuse Treatment, Prevention, and Policy*.

Principle

7

Principle 7: Utilizing a Drug User Health Framework

People who use drugs have various healthcare needs beyond overdose prevention and treatment. A [drug user health framework](#) looks at healthcare from a broad perspective that addresses structural and social barriers to improved quality of life. This approach mirrors similar ideals of harm reduction, but where harm reduction focuses on individualized approaches, this framework encompasses broad, large-scale linkages, with a particular focus on competent, compassionate provider interactions and a goal of creating more responsive and integrated systems of care. Knowledge about ACEs, trauma-informed care, mental health, SDOH, evidence-based treatment, and harm reduction [are essential](#) to understanding and applying the drug user health framework.

Service Entry Point	Immediate Needs	Health Services	Safe Spaces for Ongoing Care
- Insurance application and enrollment assistance - Navigation and linkages to social, housing, and supportive services - Navigation and linkages to health services - Transportation support	- Naloxone and overdose education - Drug checking services - Acute food, safety, legal needs - Sterile injection equipment	- Low barrier methadone and buprenorphine - Substance Use Disorder services - Mental health care - Primary and specialty care - Testing and linkages to care for HIV, HCV, and STIs - PrEP, PEP - Vaccinations	- Syringe Service Programs - Drop-in centers - Recovery Community Organizations
← SOCIAL AND ECONOMIC SUPPORT → + Peer-led outreach and engagement + Child care and parenting support + Employment assistance + Long term housing + Education support			

Table 3: Drug User Health Framework Continuum of Care, Maryland Department of Health Center for Harm Reduction Services.

The goal is to provide low-barrier, [integrated services](#) that increase access, improve service delivery timeliness, and increase the effectiveness of interventions to prevent disease and disorders that share common risk factors, behaviors, and SDOH. Delivering integrated prevention services can help individuals with complex health needs because it can improve the efficiency and the quality of services provided, maximize opportunities for comprehensive services, and reduce service duplication, procurement, and distribution costs. Providing prevention services for HIV infection, viral hepatitis, STIs, and TB for people who use drugs, including treatment for SUD and mental disorders, [requires](#) coordinated and collaborative planning approaches, an integrated service delivery plan, and a plan for monitoring and evaluating integrated service delivery.

A drug user health framework recommends providing comprehensive care for people who use drugs, which can include hepatitis C/HIV testing and treatment, mental health services, MOUD, pre-exposure prophylaxis, naloxone, and fentanyl test strips—whatever is prioritized by the person receiving care. Importantly, harm reduction services and social services are integral to meeting immediate needs, improving quality of life, and building trust for additional linkages to care. Notably, most of these services should be easy to access, a quality known as low threshold or low-barrier services, which aim to make services as accessible as possible, using a non-judgmental and flexible approach. Programs such as

these can [include](#) same-day initiation of buprenorphine or other low-barrier access to MOUD, which may not include more rigid requirements such as daily check-ins or full abstinence from all drugs.

Providers who partner with local, community-level human services providers can create a network useful to the drug user health framework. Important potential partners include: SSPs, testing centers, legal clinics, housing services, sexual wellness centers, and overdose intervention distributors. Engaging with community champions can help to create approaches tailored to the unique needs of people who use drugs in the community.

Medications for Opioid Use Disorder

[Medication-assisted treatment](#) (MAT) is a protocol for using medication to treat SUD and prevent overdose. Because other health conditions do not describe their medications as “[assisting](#)” treatment but rather assume that the medication is the core component of treatment, non-stigmatizing language suggests using more specific descriptions about the type of treatment, such as MOUD or medication-assisted recovery. MOUD is the [gold standard of treatment](#) for OUD and can reduce the risk of overdose death for people with OUD by at least 50%. Methadone and buprenorphine block the effects of short-acting opioids like fentanyl, treat opioid [withdrawal](#) and prevent relapse, and maintain opioid tolerance for any use recurrence. It can also lower the risk of contracting infectious diseases through injection drug use by [decreasing](#) the likelihood that an individual will resume injection drug use. It significantly increases survival rates and can help individuals have a more self-directed life.

Unfortunately, despite its importance, there are many [barriers](#) to accessing MOUD, including transportation, distance to travel for care, policy-mandated daily in-person visits to receive medications, stigma, substance abstinence requirements, privacy concerns, access to a provider, and insurance coverage. Telemedicine increases access to MOUD by reducing or removing some of these barriers. During the COVID-19 pandemic, many MOUD treatment centers used telemedicine to ensure patients had continued access to care. This approach proved to be very [effective](#) in retaining patients in MOUD treatment programs as well as linking them with definitive care. One [study](#) found the retention rate of MOUD with buprenorphine remained the same after individuals continued their treatment through telehealth. As such, telemedicine for MOUD should be considered a valuable treatment option for people who use drugs.

Linking access to MOUD [to SSPs](#) and providing MOUD in [medical practices](#), emergency rooms, or [community-based settings](#) can give people who use drugs increased access to lifesaving medications. Success relies on jurisdictional, specific approaches to engaging with community champions or other groups with strong community ties to enhance programming efforts. Incorporating harm reduction and MOUD into linkage to care efforts can take [multiple forms](#) depending on the organization implementing these efforts.

Maryland Trailblazers

Washington County Health Department

Services supporting people who use drugs should consider the whole person, focusing on acute needs and creating sustainable practices for recovery and general wellbeing, depending on the person's goals. The Washington County Health Department [provides](#) harm reduction services and partners with harm reduction organizations to enhance service provision in the county. To keep a low barrier to access, the SSP in the county does not require identification. Naloxone and fentanyl test strips are always offered to those seeking services, and between Jan. 1, 2022 and April 29, 2022, the department distributed over 3,100 doses of naloxone. The department's SSP hours are also extended the last Tuesday of each month to provide syringe exchange, wound care, peer recovery services, and a support group. The Washington County Health Department also emphasizes education and testing for HIV, hepatitis C and syphilis. Specifically, they have partnered with Johns Hopkins University to start a hepatitis C telehealth clinic, providing low-barrier access to hepatitis C treatment and MOUD. The department also provides information on Maryland's Good Samaritan law, including where to find more information, and provides access to [Hub City Strong Harm Reduction](#), a local harm reduction organization.



The Eastern Shore Mobile Care Collaborative at the Caroline County Health Department

The [Eastern Shore Mobile Care Collaborative](#) mobile treatment unit at Caroline County Health Department aims to increase access to care by providing MOUD for individuals with OUD in underserved rural communities to maximize access to lifesaving treatment. The treatment unit is equipped with medical supplies and telecommunication devices and staffed by a nurse and PRS. Videoconferencing technology links the unit to an addictions medicine specialist who provides point-of-care diagnosis and monitoring during follow-up visits. The unit provides the following services:



- Onsite and mobile psychiatric evaluation and treatment.
- Tele-video assessments to determine and direct patients to the most appropriate level of care.
- Psychiatry evaluation and treatment, clinical assessment, crisis intervention, medication management/monitoring and health promotion and training using interactive video conferencing.

Tools and Resources

- [“The Americans with Disabilities Act, Addiction and Recovery for State and Local Governments”](#) factsheet from New England ADA Center.
- [How We Improve Lives](#) website from HIPs, Washington, DC.
- [“Know your Rights: Rights for Individuals on Medication-Assisted Treatment”](#) document from SAMHSA.
- [“Intersecting substance use treatment and harm reduction services: exploring the characteristics and service needs of a community-based sample of people who use drugs”](#) article published in *Harm Reduction Journal*.
- [Solutions](#) website from Boom! Health, New York City.
- [Drug User Health Policy Map](#) website from NASTAD.

Perspectives of Maryland Residents Who Use Drugs

From the Statewide Ethnographic Assessment of Drug Use Services Report

The following quotes come from the Statewide Ethnographic Assessment of Drug Use Services (SEADS) Report,¹ which aimed to understand the experience of people who use drugs and who access harm reduction services in Maryland.

“ I feel like people look down on us. There's not enough information out there explaining how addiction works. It's not like we grow up thinking, like, 'when I get older, I can't wait to start shooting drugs into my veins.' My grandma who has my son thinks people can just control it. [Like] you can say, 'I'm just not doing it' one day and that works. ”

“ I will never be honest with a doctor again, let me tell you, because they will treat you like trash once you've admitted you're a drug addict. ”

“ I don't want to go see a counselor that has never been through addiction, has only been to college. You can't relate to me. You can't relate to me because you never stuck a needle in your arm. You can't relate to me because you never held a crack pipe to your lips. You can understand but you can't relate. ”

“ I just feel like people in general look at addicts negatively. The whole argument that we choose to do this to ourselves, like we enjoy it or something. I mean, of all the things about me, it's one of the last things I like to share to a stranger. I'd almost rather tell people I'm a felon than an addict, just because of the judgment, which is sad. ”

“ It's next to impossible. They immediately write me off. They think I'm pill chasing....I don't [want to] immediately burst into tears and want to tell them all my life problems, but I feel like without that explanation they're not going to even consider it. And...a walk-in isn't gonna get me that opportunity. I don't get any further than a walk-in before they're turning me out, turning me out the door. ”

“ And I also believe that once [providers] do know about you, that they pass judgment on certain things. Like they haven't treated me the same since they found out I'm on methadone. They haven't. And it's—I think it's a stigma. I think that [service providers are] terribly against methadone or Suboxone or any medically-assisted treatment. They don't like it. And they will tell you they don't like it. They say it's a crutch. 'You're just using that instead. ”

¹ University of Maryland Department of Anthropology. “Statewide Ethnographic Assessment of Drug Use Services.” Available at <https://anth.umd.edu/project/statewide-ethnographic-assessment-drug-use-and-services-%28seads%29>. Accessed 10-4-2022.

“

I think [hospital name], and maybe it's getting a little better, turns a blind eye...they place a stigma on the addicts...when I got my DUI, I'd overdosed while I was driving, and I mean, I went to the hospital and I didn't even have a room. They kept me in the hallway... the officer came, he wrote me a ticket, handed it to me, the nurses were rude. I mean it was like I was a piece of trash... it's like I wasn't important enough to be put on their caseload, like they had better things to do.

”

“

Because we're, like, separated from everyone else and stigmatized and stereotyped, but we are just regular people trying to live in society just like everybody else, except we're sick.

”

Conclusion

The seven guiding principles for linkage to care efforts for people who use drugs outlined in this toolkit are: (1) incorporating harm reduction, (2) implementing a trauma-informed approach, (3) addressing stigma, (4) accounting for social determinants of health, (5) integrating peers, (6) intensive case management, (7) and incorporating the drug user health framework. By addressing each of these guiding principles and prioritizing relationship-building and increased engagement, providers and partners can make linkages to care more effective and efficient for people who use drugs. Public health is well situated to partner across linkage-to-care settings to support help partners implement each principle and ultimately reduce substance-related morbidity and mortality.

Appendix A: Implementing Guiding Principles into Primary Care Settings

Primary care providers play an important role in linking people who use drugs to care. This appendix highlights principles discussed in this toolkit and how they are applied specifically in the primary care setting.

Both the American Medical Association and the American Academy of Family Physicians recognize the importance of primary care providers and their role in treating patients who use drugs. “Primary care providers are uniquely positioned to identify and address unhealthy substance use or misuse in their patients,” [according](#) to the American Medical Association. The [American Academy of Family Physicians](#) “strongly urges its members to be involved in the diagnosis, treatment and prevention of SUD as well as the secondary diseases related to their use. Education in the treatment of all aspects of these complex disorders, including knowledge and usage of evidence-based strategies, should be a defined part of medical school and family medicine residency curricula.”

We explore principles on harm reduction, social determinants of health, stigma, and a drug user health framework more extensively on the following pages. While these principles are [designed](#) for academic detailing, “a noncommercial, evidence-based educational outreach method focused on clinician education and behavior change,” primary care providers and their teams can use them as well.

The Maryland Opioid Academic Detailing Project offers evidence-based information to support therapeutic decisions specific to pain management and SUD. Academic detailers in Maryland are trained public health professionals who offer brief visits with practitioners to discuss their needs in prescribing controlled dangerous substances, supporting patients with pain management needs, and referring or offering SUD treatment. Academic detailers connect practitioners with evidence-based, clinically relevant, and actionable resources offered by their local, state, and federal health agencies.

[Health Management Associates](#), a leading independent national research and consulting firm in the healthcare industry, helped develop this appendix. The team is familiar with the Maryland landscape, specifically the Maryland Primary Care Program, and the funded initiatives of CDC’s [Overdose Data to Action](#) cooperative agreement.

See the [Maryland Primary Care Program](#) website for more information. If your primary care office is interested in receiving a visit from an academic detailer or wants to learn more about this work, email mdh.pdmp@maryland.gov.



1

Provide Intranasal Naloxone



Overdose education and naloxone distribution at the site. Practices can implement changes in EMRs to support consistent co-prescribing of Naloxone with MOUD Prescriptions.

MOUD (Medication for Opioid Use Disorder) Providers may apply to become a dispensing Overdose Response Program (ORP) by following

10 Easy Steps



Please note that the Naloxone Standing Order allows individuals without prescribing privileges to dispense naloxone under the LHCP's license. For entities interested in applying for naloxone that are not authorized as Overdose Response Programs, email mdh.naloxone@maryland.gov.

2

Counseling on Overdose Prevention Strategies



Providers and team members should counsel patients on strategies to reduce the risks of overdose. This includes educating about the risk in changing methods, educate on the risk of fentanyl and provide fentanyl test strips.

The Maryland Harm Reduction Training Institute (MaHRTI) website provides live and on-demand courses.



To apply for fentanyl test strips only, you must be a non-profit or government entity. If your organization qualifies, you can request naloxone and/or fentanyl test strips at any time. For more information on how to place an order or further assistance, please email mdh.access@maryland.gov.



Providers can purchase Fentanyl test strips from Ovus Medical.



3

Develop an opioid overdose response protocol



Primary care practices should prepare staff to respond to and reverse opioid overdose by educating staff on the signs of opioid overdose and next steps.

Providers can access a video Here



For ASL Training Click Here



4

Offer Treatment on Demand and Implement a Patient Centered Approach to MOUD

Flexible scheduling promote access for patients with high needs.



Implement a Patient Centered Approach to MOUD by prioritizing patient perspective and choice around medication selection and dose using a shared decision-making framework.



MACS provides support to prescribers and their practices, pharmacists, and healthcare teams in addressing the needs of patients with substance use disorders and chronic pain management. For more information click here: <https://www.marylandmacs.org/>

Addressing Social Determinants of Health in Primary Care Settings



Social determinants of health (SDOH) are the complex set of factors outside of medical care that influence health outcomes, both at an individual and population level. To understand the needs their population, providers can add SDOH questions to their intake. Health Leads has developed the following questionnaire as part of the Health Leads Social Needs Screening Toolkit.

ENGLISH Screening Questions*

Please collect this information when the participant starts services or begins to participate in activities. The participant can fill this out on their own, or you can ask them the information. Information will be kept strictly confidential. Only the program staff and the researchers will see individual information. Information that is shared outside of program staff and researchers will not have names on it and will be grouped together with information from other participants.

Today's Date: _____

Participant's Name: _____

Question	Yes	No
1. In the last 12 months*, did you ever eat less than you felt you should because there wasn't enough money for food?		
2. In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?		
3. Are you worried that in the next 2 months, you may not have stable housing?		
4. Do problems getting childcare make it difficult for you to work or study?		
5. In the last 12 months, have you needed to see a doctor, but could not because of cost?		
6. In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?		
7. Do you ever need help reading hospital materials?		
8. Do you often feel that you lack companionship?		
9. Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight		
10. If you checked YES to any boxes above, would you like to receive assistance with any of these needs?		

*These questions are part of the Health Leads Social Needs Screening Toolkit.

SPANISH Preguntas de detección*

Por favor recopile esta información cuando el participante empiece a recibir servicios o a participar en actividades. El participante puede rellenarla por sí mismo o usted puede pedirle la información. La información será estrictamente confidencial. Sólo el personal del programa y los investigadores verán la información individual. La información que se comparta fuera del personal del programa y los investigadores no tendrá nombres y se agrupará con la información de otros participantes.

Fecha: _____

Nombre del participante: _____

Pregunta	Si	No
1. En los últimos 12 meses, ¿comió menos de lo que creía que necesitaba porque no le alcanzaba el dinero para la comida?		
2. En los últimos 12 meses, ¿lo(a) amenazó con suspenderle el servicio en su casa la compañía de electricidad, gas, combustible o agua?		
3. ¿Le preocupa quedarse sin vivienda estable en los próximos dos meses?		
4. ¿Conseguir cuidado de niños le dificulta trabajar o estudiar? (Dejar en blanco si no tiene niños.)		
5. En los últimos 12 meses, ¿necesitó ver a un médico pero no pudo por el costo?		
6. En los últimos 12 meses, ¿alguna vez dejó de recibir cuidados de salud porque no tenía cómo llegar al sitio?		
7. ¿Alguna vez necesita ayuda para leer los materiales del hospital?		
8. A menudo siento que me falta compañía.		
9. ¿Es urgente alguna de estas necesidades? Por ejemplo: No tengo qué comer esta noche, no tengo dónde dormir esta noche.		
10. Si marcó que sí a cualquiera de las casillas anteriores, ¿le gustaría recibir ayuda con cualquiera de estas necesidades?		

*These questions are part of the Health Leads Social Needs Screening Toolkit.

Addressing Stigma in Primary Care Settings

Include ALL Staff in Primary Care Settings in Anti-Stigma Efforts, Education, and Training

Any healthcare employee who encounters a patient or client can stigmatize; therefore, [working](#) with all health workers is important! As soon as patients and clients leave their appointments, they should not experience stigma with anyone. This means primary care practices should train **all** staff who are interacting with patients in their anti-stigma efforts. This includes:

- Primary care physicians
- Nurse practitioners and physician assistants
- Registered nurses, licensed practical nurses, advanced practice nurses, and clinical nurse specialists
- Certified nurse midwives
- Certified registered nurse anesthetists
- Licensed pharmacists
- Clinical social workers
- Medical and patient care technicians
- Physical therapists
- Dietitians
- Paramedics
- Interpreters
- Administrative staff
- Interns and medical students

Pursue Trainings from the Anti-Stigma Project

The [Anti-Stigma Project](#) was formed in Maryland in 1993 by the Maryland Mental Hygiene Administration in collaboration with On Our Own of Maryland, Inc. to reduce stigma and discrimination within the behavioral health system. The organization fights stigma by raising consciousness, facilitating ongoing dialogues, searching for creative solutions, and educating all participants within or connected to the behavioral health community, including peers, family members, providers, educators, and administrators. For close to 30 years, providers and people from varied professional backgrounds and lived experiences have benefited from the anti-stigma workshops. To schedule a private workshop for your practice, please email training@onourownmd.org. Online educational courses are also [available](#) and provide Maryland CPRS CEUs.

Identify Stigma in Interactions, Expectations, Language, and Policies

One strategy is to confront bias and stigma in discussions with primary care staff. The Building Collaborative Capacity Series [describes](#) ways to create collaborative teams, communication protocols, and practice innovations. Another strategy is to examine pictures, posters, and written materials in spaces where interactions with patients and clients take place to ensure that they demonstrate inclusivity.

Make Mindful Language Choices and Recognize that Words Have Power

The shift from using identity-first (drug abuser) to person-first (parent with a SUD) language demonstrates individuals have a “treatable” problem and their disorder does not define them. The National Institute on Drug Abuse [offers](#) a course on stigma and addiction, terms to avoid when talking about addiction, and how we can change stigmatizing behavior.

Share “**Words Matter**” posters and materials in the rooms where primary care staff work and relax to ensure this language is always kept top of mind. The American Hospital Association has worked with behavioral health and language experts from member hospitals and partner organizations to release a series of downloadable posters to help your staff adopt patient-centered, respectful language. Please

consider downloading, printing, and sharing these posters with team members and encouraging them to use this language both in front of patients and when talking to colleagues. You can [download](#) the “People Matter, Words Matter” posters to share in your primary care practice and learn more about strategies for [disrupting stigma](#) in your practice.

Utilizing a Drug User Health Framework

People who use drugs have various healthcare needs beyond overdose prevention and treatment. A [drug user health framework](#) looks at healthcare from a broad perspective that addresses structural and social barriers to improved quality of life. This approach mirrors similar ideals of harm reduction, but where harm reduction focuses on individualized approaches, a drug user health framework encompasses broad, large-scale linkages, with a particular focus on **competent, compassionate provider interactions** and a goal of **creating more responsive and integrated systems of care**. [Integrated services](#) can increase access, improve timeliness of service delivery, and increase the effectiveness of interventions for people who use drugs.

Primary care practices should utilize the checklist below to ensure they are offering the most appropriate services and care. Does your practice provide these services in-house?

- Mental health services
- MAT and/or MOUD
- Pre-exposure prophylaxis
- Hepatitis C and HIV testing and treatment
- Naloxone
- Fentanyl test strips
- Legal services
- Housing and advocacy services

Primary care practices should include these services to create a better opportunity for people who use drugs to be linked to the care they need. **Other considerations for ensuring service integration in primary care practices include:**

- What efforts does your practice have in place to support integrating screening, assessments, and interventions?
- Do you have care coordination between your general health system and specialty SUD treatment programs or services?
- Does your practice have strong and trusted referral networks, including with community-based harm reduction services?
- Does your practice track referrals to social services and support?

WHAT DOES EVIDENCE SHOW?

Integrating services for **primary care, mental health, and substance use-related problems together** produces the best outcomes and provides the most effective approach for supporting whole-person health and wellness.³ **Research shows that closer integration of substance use-related services in mainstream healthcare systems will have value to both systems** (see footnote).

What does integration do?

Integration can help address health disparities, reduce healthcare costs for both patients and family members, and improve general health outcomes.

Appendix B: Implementing Guiding Principles into Community-Based Organizations

AHEC West Associate Director Melissa Clark repeats her mantra, a verbal calling-card issued with bright, smiling eyes that bely a steely, determined commitment to a personal and professional mission to save lives and restore hope amidst the devastating overdose epidemic gripping Allegany County and its county seat, Cumberland: “Teamwork makes the dream work!”

And she means it.

Until a few years ago, this has mostly been a motto meant for staff at AHEC West, challenging us to cooperate across programs and initiatives, breaking down silo walls at the Cumberland-based Area Health Education Center that can impede progress and inhibit success. This is now the calling card of AHEC West as an organization in our community.

It is a testament to humanity’s resilience, demonstrated in the face of countless societal challenges over the millennia of our existence, that hope truly does spring eternal. But like springtime blooms that fade beneath the full leafy canopy of summer, hope that is not rooted in hard work, commitment, and knowledge will prove ephemeral, fleeting, and ultimately false.

AHEC West at its heart, as a community-based organization (CBO), seeks to build a strong, enduring foundation for hope in Allegany County, Maryland, a rural community at the epicenter of the overdose epidemic, by strengthening and expanding prevention, treatment, and recovery services linked to OUD and SUD.

Located on Maryland’s mountainous western panhandle, Allegany County is bordered to the north by Pennsylvania and the south by West Virginia. Covering 430 square miles, the county is bookended in the east by Washington County and to the west by Garrett County. With a population of 71,500 (U.S. Census estimate 2018), it is the 15th most populous of Maryland’s 23 counties. Based on per capita income, Allegany County is the second-poorest county in Maryland. The county seat is Cumberland, where many of the challenges associated with SUD/OUD in Allegany County are concentrated.

The [mission](#) of AHEC West is “to improve access to and promote quality in healthcare through education and collaboration,” which has guided the agency since its founding in 1976. AHEC West has taken the lead on numerous federal, state, and local healthcare initiatives, working closely over the years with state and county health departments, regional hospitals, universities, school systems, county and state governments, and individual healthcare providers. A CBO like AHEC West can be the backbone of any region with priorities, partnerships, and relationships to improve the life of the residents they serve. Identifying the needs of a community, providing services that help improve the social determinants of health, and providing direct assistance, CBOs can guide and find solutions to problems a community is facing. Through its collaborative, integrated approach to OUD/SUD in Allegany County, the [Healing Allegany Consortium](#) was developed.

The consortium was formed as part of the [Rural Communities Opioid Response Program](#) FY19 Planning Grant and three-year Implementation Grant (FY20-FY23). The effort began at the grassroots, with more than a half-dozen focus groups convened to provide a ground-level view of the overdose epidemic ravaging the county. Teachers, members of the faith community, people experiencing homelessness, first responders, and social workers were among the groups AHEC West convened, but perhaps the most riveting was the focus group composed of county residents in recovery from SUD. These folks are an inspiration, embodying mountains climbed and summits won in the struggle against addiction,

despair, and hopelessness. But it was no rainbow bridge to sunny days unending, no streamers of victory, no satisfied glow of foe vanquished and gone forever.

As a CBO, AHEC West knows the joy that linkages to care and needs of the community can be met without the “red tape” of some government organizations. Partners also enjoy the idea that as a CBO, linkages to care can happen faster and more effectively. AHEC West works in tandem with all organizations, both community-based and governmental. Since its beginning, it has found much success in educating the community about stigma, an ongoing and uphill battle. AHEC West has developed a PRS peer group comprised of over 30 peers in the region. Currently, there are [five peers](#) employed as part of the AHEC West team who are dispersed throughout the county in various areas helping those who need it. They [share](#) their stories so others can better understand their journey to recovery. AHEC West also took the lead on harm reduction in the county where, in the past 18 months, over 2,200 doses of naloxone, hundreds of fentanyl test strips, and many safe sex kits, have been distributed. Now, AHEC West is implementing a new syringe service program funded by the Maryland Department of Health.

AHEC West staff know the importance of recovery and meeting those in need “where they are.” As a CBO, AHEC West can be more efficient and direct in working with residents in need. The residents in a small rural area get to know those who want to help them, and they trust and share with others. The trust is not always as easy or comfortable with a governmental agency. By meeting them where they are, AHEC West can go to the homeless encampment where many other partners are restricted due to their policies and procedures. The [Street Team](#) is the boots on the ground for AHEC West and other partners. AHEC West has been welcomed and embraced by the Cumberland City Police Department, Allegany County EMS, Allegany County Detention Center and Allegany Pretrial Release, and Allegany County Drug Court, among others, to help make changes in thinking and supporting those in need. AHEC West has worked closely with the development of an Oxford House in the County targeted for women in recovery as well as their children. This is set to open in Spring of 2023.

As everyone knows, recovery from SUD/ODU is a journey, not a race, not only for the individual but for the community. But being on the forefront of what is happening and using that to drive the work to be done is important. At AHEC West, we pride ourselves on being that guide to help make the community better in any way we can. As written in a grant recently, “Eighteen years sober and similarly removed from a stint in county jail, AHEC West PRS Jeff Hay gets up every single day to meet that person and the community to help.”

Trauma Informed Education

Mind Body Medicine

Partners and some staff offer Mind Body Skills groups within the community

Yoga for 12 Step Recovery

Trained Y12SR staff member works to bring yoga into the detention center for both residents and staff

SAMSHA

Staff member certified to train How Being Trauma-Informed Improves Criminal Justice System Responses for Law Enforcement, Judges, and Case managers.

Testimonial from a Peer

"We meet people where they are. Where they are may be a place that is hard to be in or a result of continual exposure to a traumatic situation I want to be as non-judgmental and openminded to what a person wants as possible, life is hard enough and you never know what a person is going through so I want to just approach each person with kindness and not leave them there alone.

If you are meeting with a Peer, the likelihood that you have experienced trauma is great. It might be a person's worst day and we help give them the chance to have better days by supporting them and standing with them. "

-AHEC West Peer Volunteer



Healing Allegany

www.ahecwest.org/healingallegany



SAMHSA



Center for Mind Body Medicine



Y12SR

Addressing Stigma

Anti-Stigma Campaigns



- Community education utilizing radio & digital advertising
- Social media campaigns with a call to action
- "Language Matters" mailers
- Newspaper ads
- Peers using their personal stories to advocate and educate on varying levels while tailoring education to different messages based on the audience, holiday or season.

OUR GOAL IS TO STOP THE STIGMA!

Allegany Goes Purple

Aims to help prevent the misuse of opioids and other substances through awareness, education, community support, and advocacy.

The campaign seeks to demonstrate support for those who are working to overcome addiction, as well as family members and friends caught in the devastation of the opioid epidemic.



Testimonial from Attendee

"The most useful part of this training was learning about how our stories can help change lives of people who are still suffering from use disorder."

Faces and Voices of Recovery Training

PurpleFest!

Healing Allegany will kick off a countywide celebration of National Recovery Month with PurpleFest, a free festival to be held Sunday, Aug. 28 featuring live music, numerous vendors and MTV celebrity guest speaker Brandon Novak.



Healing Allegany

www.ahcwest.org/healingallegany

Implementing Harm Reduction

Harm Reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

Street Team

Boots-on-the-ground targeted street and stationary outreach initiatives.

Provides Naloxone, Fentanyl test strips, safer use and safer sex materials, wound care supplies, and warm/cold weather gear.

Day of Access

Collaboration with local treatment providers and recovery resources to remove barriers of access for individuals to receive treatment or initiate inpatient services.

Partnerships

Pressley Ridge	Home Builders & Recovery Life Building Education
Western Maryland Consortium	Job Services
Horizon Goodwill Industries	Access to Housing Navigation Resources
Allegany County Health Department	Wound Care Supplies & Overdose Response Tracking
Law Enforcement	Drug Abatement & Response Team, Drug Take Back
Allegany County Library System	Stationary Outreach Sites
Treatment Providers	Stationary Outreach & Day of Access to Treatment
Office of Consumer Advocates	Stationary Outreach



Street Team Calendar



Healing Allegany

www.ahecwest.org/healingallegany



Syringe Service Programs

Outreach



Stationary Outreach



Mobile Outreach



Special Events

Social Determinants of Health

Community Health Worker Training

The Maryland AHEC CHW training program is accredited by the Maryland Department of Health.

The program is designed for anyone looking to work in the field of community and public health, as well as those already established and looking to enhance skills.

Our mission is to train CHWs to help bridge the healthcare gap for our rural and/or underserved communities. These CHWs will be able to identify and facilitate access to resources, navigate the healthcare system and provide health education.

Path2Help

A community based referral pathway. P2H opens doorways while simultaneously conducting a needs assessment to individualize access to resources.

Navigation tool can be accessed by both community members as well as social service providers.



Path2Help

TESTIMONIAL

"I have witnessed people receiving resources and making connections through the Path2Help platform. I see firsthand the highest areas of need in our community and report to those that can help address our local social determinants of health. Path2Help is an amazing resource that provides our community with reliable resources to promote help, health, awareness, connections, and support."

-Carey Moffat, UPMC Western Maryland,
Coordinator of Path2Help

Regrounding our Response

This training is an effort to increase equity in healthcare and provide education, as well as eliminate bias. AHEC West staff members were trained as Master Presenters of all Regrounding our Response subjects.

Integrating Peers

Peer Recovery Specialists are a Lifeline to Many

Peers are an integral part of all treatment teams. They are relatable, have been in similar situations and have lived experience. People who use drugs and their families and friends can relate and see recovery is possible!

Peer Support Network

AHEC West established monthly meetings to create an outlet for local Peers to connect, share resources, educate, and collaborate.

Community Immersion

AHEC West Peers receive referrals from a multitude of providers, including:

- Self-Referrals from Community Members
- City Law Enforcement
- Treatment Providers
- Horizon Goodwill Industries
- Allegany County Parole and Probation
- Drug Abatement and Response Team
- Allegany County Sheriff's Office / Detention Center
- Allegany County Drug Court



The Healing Allegany Street Team consists of Peers and volunteers to work within our community to educate and help in all areas of need.



Healing Allegany

www.ahecwest.org/healingallegany

Testimonial from a Partner

"Having the ability to talk to a Peer Recovery Specialist who directly lived life and struggled in the same shoes and with the same problems has been tremendously valuable to some of our clients. And it's not just the ability to talk to a friendly face. The wealth of knowledge with respect to treatment options, the contacts, the ability to get people access to treatment, this expertise has been worth its weight in gold in getting people help in a timely manner. There's no doubt in my mind that the Peer Recovery Specialists enhance tremendously the value and effectiveness of our program."

- Chapin Jewell, Judicial Unit Manager, Alternative Sentencing Division,
Allegany County Sheriff's Office

Appendix C: Implementing Guiding Principles into the Hospital Setting

Hospitals are critical in linking patients to care in the community. They can serve as a hub for community-based resources through developing and maintaining relationships with community providers, treatment centers, and connections to the social safety net. The hospital may be the first place a person who uses drugs has contact with the health care system. Therefore, it is critical to minimize any potential stigma associated with their substance use and ensure they are connected to community resources that can support their identifiable needs. This appendix describes how hospitals can implement the toolkit guiding principles to support patients who are at high risk for overdose and connect them to the support they need in the community.

Become an Overdose Response Program and ensure all patients with risk for opioid overdose are provided naloxone.

By June 30, 2023, the MD Statewide Targeted Overdose Prevention Act requires all hospitals to offer an overdose reversal agent, free of charge, to a patient who has received treatment for a SUD, OUD, or nonfatal drug overdose event. Hospitals may already have established protocols for the distribution of naloxone in the emergency department setting. However, there is an opportunity to expand the distribution of overdose reversal agents to patients at discharge from the inpatient setting and into the numerous ambulatory clinics located within hospitals. Hospitals may apply to become a dispensing Overdose Response Program (ORP) and receive free naloxone for distribution from the Maryland Department of Health by [following](#) 10 easy steps.

Please note that a Naloxone Standing Order established under [Health-General Article § 13-3106](#), allows individuals without prescribing privileges to dispense naloxone under the licensed healthcare professional license. For entities interested in applying for naloxone that are not authorized as ORPs, email mdh.naloxone@maryland.gov.

Establishing relationships with syringe services programs (SSPs) for patients identified to be active IV users or patients seen in hospital for non-fatal overdose.

In addition to becoming an ORP, hospitals can also implement harm reduction practices by establishing relationships with SSPs around the state to refer patients who have a history of active injection drug use. Providers can refer to the [Maryland SSP guide](#) for an updated list of programs around the state. These programs provide people who inject drugs with clean syringes and other drug paraphernalia as well as assistance with wound care, and referrals to definitive care for hepatitis, HIV, and MOUD.

Integrate Peers in Linkages to Comprehensive Care in the Hospital Setting.

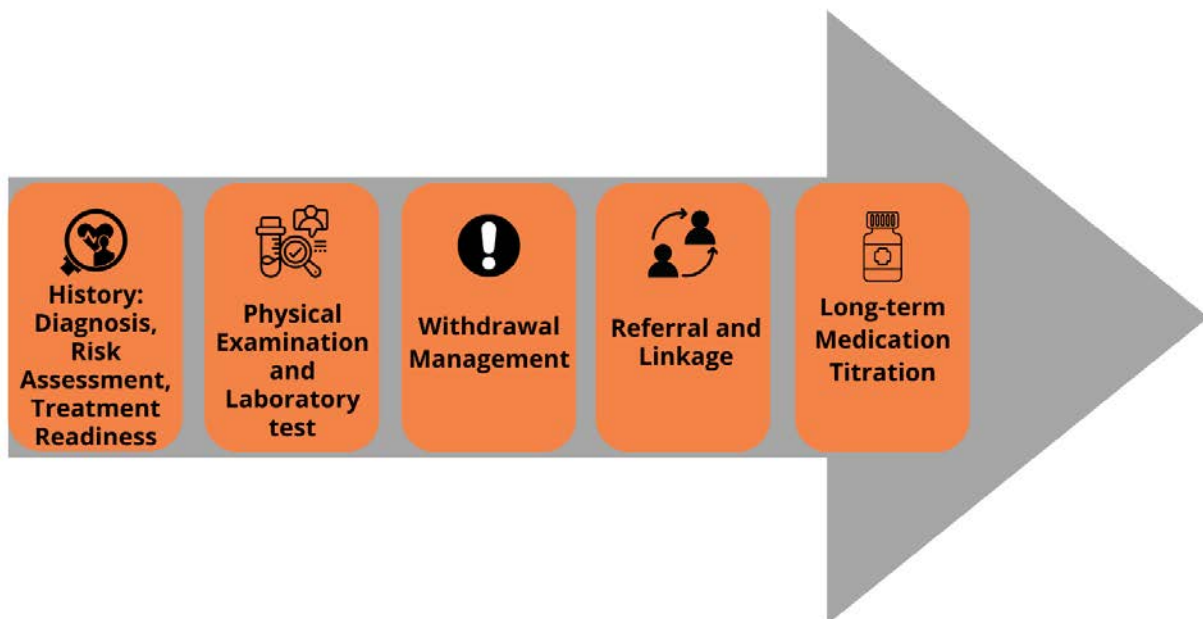
Peers can play a vital role lowering stigma and developing a rapport with people who use drugs within the hospital setting. This is particularly true in the emergency room setting after a non-fatal overdose. PRS utilize Screening Brief Intervention and Referral to Treatment techniques to be able to help patients identify whether they have a SUD and to motivate those patients identified with a SUD to pursue treatment. The *Referral to Treatment: Brief Intervention for a Patient in the Severe Zone* tool [created](#) by the University of Missouri-Kansas City provides a stepwise example of how a referral to treatment process takes place.

For hospitals looking to implement a PRS program in their emergency departments, the [Mosaic Group](#) works with health systems to hire peers and incorporate those peers into the workflow of emergency departments. For additional information on how to incorporate peer services into your workflow, please send an email to Sadie Smith at ssmith@groupmosaic.com.

Applying a Drug User Health Framework in the Hospital Setting

People who use drugs are admitted to the hospital for a wide range of medical conditions. While the workup and treatment of a patient's primary admitting diagnosis is the focus of most hospital efforts, the care team in the hospital can take a proactive role in identifying the social determinant needs a patient has and develop plans to address these needs prior to the patient leaving the hospital. Given the wide range of ambulatory clinics associated with hospitals in Maryland, ensuring that patients have follow up appointments scheduled with a primary care provider, or are connected to subspecialty clinics like wound care services not only help patients get the care they need, but these strategies also reduce readmission rates which are directly tied to hospital reimbursement.

In addition to ensuring a patient's post-hospitalization needs are addressed prior to discharge, hospitals can further their application of a drug user health framework within the hospital setting by developing an inpatient addiction medicine consultation service. Research [suggests](#) that these services can reduce 90-day all-cause mortality for patients with identified SUD when compared to controls. Furthermore, the use of an inpatient addiction medicine consult service can help the primary team identify additional issues related to a patient's SUD. Components of an addiction medicine consultation are outlined below:



Finally, and most importantly, hospitals can play a pivotal role in connecting patients to definitive treatment for their SUD. Additionally, hospitals can work to establish referral relationships with all the various treatment providers in the community as part of their community outreach services. People who use drugs or those who care for them can consider this [Be Empow\(ER\)ed](#) know your rights resource from the Legal Action Center to understand what services can be provided by an emergency department and how to navigate any potential barriers.

Appendix D: Implementing Guiding Principles into the Opioid Treatment Program Setting

Opioid Treatment Programs (OTPs) offer the gold standard of treatment for OUD and serve as a prominent resource for many people who use drugs. People who use drugs may come to OTPs with past negative experiences with the medical system. Providers at an OTP can rebuild trust with people who use drugs and help them re-envision what medical care may look like for them. When providers affirm a patient's efforts in treatment and deliver care that acknowledges the intersecting issues with SUD, patients are [more trusting](#). As such, it is important for OTPs to embrace the principles laid out in this toolkit and look to connections with outside resources when necessary. OTPs are often limited in capacity for services beyond medication and counseling due to barriers such as staffing, reimbursement, and regulatory issues.

Implementing Harm Reduction in the OTP Setting

OTPs can support patients by stabilizing patients with MOUD and/or MAT and reducing their illicit substance use and connect them to local harm reduction services, such as through a warm handoff or [providing](#) harm reduction services onsite. A recent study [shows](#) that co-locating services may be the best way to keep patients engaged. OTPs can also avoid discontinuing MOUD or cutting dosages due to illicit use, unless clinically indicated. Abrupt changes in MOUD can increase the likelihood of [negative](#) consequences, including withdrawal or fatal overdose. Missed dosage could lead to [obtaining](#) an illicit substance and with the increasing risk for overdose. As MOUD on its own reduces the risk of overdose, even if illicit use continues, MOUD should be prioritized. OTPs should develop alternative protocols to deal with continued illicit use that do not involve disruption of MOUD.

Integrating Peers in the OTP Setting

At any service point, having a peer on staff can help a person seeking services feel safe. OTPs are no exception. Peers are valuable to keep patients [engaged](#) and provide opportunities to share their treatment progress, barriers outside of treatment, and stigma they are experiencing. Peers can also serve as an additional resource and source of perspective to help a participant navigate additional levels of treatment (e.g., intensive outpatient treatment), resources for housing, food, and local support groups.

Addressing Stigma

[Only about a quarter](#) of people with a need for substance use treatment have accessed MOUD in the last year, and stigma is often referenced as the main barrier to MOUD access. [Stigma has been shown](#) to dissuade people with SUD to access MOUD, or prematurely leave treatment. It is important for OTP providers, from physicians to counselors, to be educated on MOUD so they can dispel concerns or falsehoods. OTP providers should also be prepared to champion MOUD as an evidence-based form of care in instances where a patient's support system may oppose this treatment. An example of a campaign to combat stigma, specifically against MOUD, can be found [here](#). OTPs can address stigma by:

- Encouraging patients to see MOUD as a medication to reduce or eliminate substance use, not a substitute drug.
- Questioning and addressing stigma-related concerns a patient may have and providing safe space for a dialogue.
- Providing anonymous "real patient" stories to demonstrate the effectiveness and progress people can have in their lives due to stabilization on MOUD.
- Supporting patients to see MOUD as a step in the transition from illicit substance use to stabilization (e.g., it is okay to not stop all drug use the minute they start treatment).
- Explaining that optimal dosing takes time so that participants do not prematurely leave treatment.

Drug User Health Framework

People who use drugs can be wary of accessing medical services due to fear or history of judgment or stigma related to their drug use. OTPs are well positioned to develop relationships with these people and assist them in getting access to additional quality and judgment free medical care. From a drug user health framework perspective, OTP can assess where on the continuum a patient is and assist this person in making the necessary connections to address their needs. Integrating a warm handoff system for services an OTP is unable to provide can help ensure participants [access](#) the services they may need or want. Pew Charitable Trusts also outlines how OTPs can [improve](#) their programs through patient-centered care and tailored services. Examples of services include:

- Developing relationships with PHP and residential treatment programs to facilitate increased levels of care for patients with demonstrated need.
- Evaluating whether patients have established relationships with a primary care provider
- When indicated, ensuring patients with more complex health needs are connected to relevant providers (mental health services, prenatal care, infectious disease care, etc.)
- Facilitating medical chart sharing should a patient have to enter inpatient hospital care for other health conditions. In Maryland this can be facilitated by the OTP becoming a data sharing partner in CRISP in order to access a participant's hospital records, and patients can sign a [CRISP Consent Tool](#) so that dosing information can be shared to the hospital during their stay.

Social Determinants of Health

An OTP may be the only location a person who uses drugs accesses services. Given the [prevalence of comorbid conditions with SUD](#) (e.g., mental health disorders, chronic pain, tobacco use, infectious diseases) and complex social needs, such as [poverty and unemployment](#), OTPs must be prepared to assist or refer for additional services. OTPs can better address social determinants of health by developing a network of community-based organizations which support housing, food insecurity, identification card renewals, and other social safety net services. This list can be shared with all OTP providers and/or displayed in the lobby for patients to review. When possible, a clinician should [directly](#) connect a patient with services to increase the likelihood of uptake rather than use passive approaches.

Maryland Trailblazers

Overdose Response Programs

The Center for Harm Reduction Services in the Maryland Department of Health oversees authorization and compliance of [Overdose Response Programs](#). This authorization allows an entity to access naloxone free of charge from the Department of Health. As of March 2022, around 44% OTPs in Maryland are authorized as ORPs, which shows great initiative to implement harm reduction in an OTP setting. The [STOP Act](#) will require by June 30, 2023 that all OTPs have a protocol to provide naloxone free of charge to participants at risk of experiencing an overdose. This naloxone will be provided to OTPs from MDH.



Reach Health Services

The Institute for Behavioral Resources [REACH Health Services](#) program has fully integrated PRS into daily operations of their OTP. At REACH, peers are responsible for providing support to patients and will go to hospitals and other facilities, including Baltimore City Detention Center. Peers meet patients to transport them to treatment, distribute naloxone, provide case management and referrals to ancillary services (e.g., food or shelter), support needs, accompany

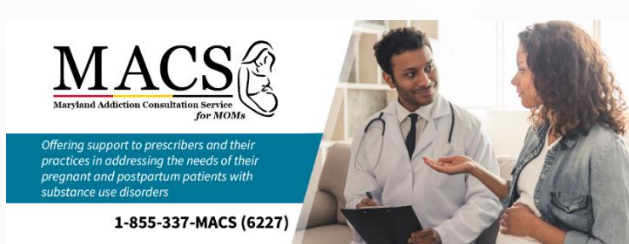


patients to medical appointments, and assist in the transition between various healthcare services. In addition, peers work with counseling staff to refer patients to more intensive treatment referrals and provide general support with daily struggles of recovery and assistance in maintaining abstinence.

Maryland Addiction Consultation Services for MOMS

Maryland Addiction Consultation Services (MACS)

for MOMS is a program administered by the University of Maryland School of Medicine that supports healthcare providers treating pregnant and postpartum patients with SUD. MACS for MOMS offers consultation for clinical services, resources, and referrals via a call line, online request form, or email request. The program also shares connections for training, such as the DATA 2000 waiver, and other continuing education opportunities. Lastly, the program hosts a monthly ECHO clinic where providers apply case-based learning. The support provided from MACS for MOMS is available for all providers engaged in maternal healthcare.



Health and Recovery Practice

Health and Recovery Practice (HARP) at the University of Maryland offers screening for conditions common with SUD, such as mental health disorders, chronic medical conditions, and infectious diseases in an OTP setting. HARP also offers coordinated care with physicians, psychiatrists, psychologists, nurse case managers, social workers, and PRS on site. Services offered include family planning, contraception, naloxone dispensing, and PrEP.



Appendix E: Maternal and Child Health

This appendix is intended as a guide to assist healthcare practitioners in reducing substance-related mortality and morbidity experienced by pregnant people with substance use disorders (SUD) and their infants. This section will offer an overview and suggest best practices for working with pregnant people living with SUD. It also aims to encourage comprehensive care coordination and mobilize health care, social service, and other care providers to orient their actions toward addressing social determinants of health related to poor birth outcomes.

Abbreviations

CME/CE: Continuing Medical Education/Continuing Education

CPS: Child Protective Services

IPV: Intimate Partner Violence

MI: Motivational Interviewing

NAS: Neonatal Abstinence Syndrome

NOWS: Neonatal Opioid Withdrawal Syndrome

NOI: Notice of Intent

OTP: Opioid Treatment Provider

PCSS: Providers Clinical Support System

PTSD: Post Traumatic Stress Disorder

SBIRT: Screening, Brief Intervention, Referral to Treatment

Quick Facts

- Pregnant people who use drugs face unique internal and external stigmas which negatively impacts the quality of care and support they receive. They often face questions about their ability and willingness to parent their child and doubts regarding their physical and mental health. They also experience a large degree of guilt and shame, which further prevents them from seeking and receiving adequate support.
- Contrary to popular misconceptions, poverty, isolation, inadequate nutrition, food insecurity, and lack of access to quality health care can have a greater impact on the health of a baby than prenatal drug exposure.
- Pregnant people who use drugs are criminalized and punished at the state and federal level, which worsens their health outcomes.
- Although substance use disorder affects people of all classes, genders, and races, white women are more likely to use substances while pregnant, though Black and poor women are much more likely to be prosecuted.
- Pregnant people drink less alcohol, smoke fewer cigarettes, and use fewer illicit substances than non-pregnant people.



- Two thirds of women with substance use disorder experience co-occurring mental health disorders such as anxiety, depression, mood disorders and post-traumatic stress disorder (PTSD). Additionally, many (50-90%) have experienced sexual and/or physical abuse in childhood and/or adulthood, as well as intimate partner violence (60-80%). Pregnant people who experience intimate partner violence (IPV) and other types of abuse are less likely to use contraception and receive prenatal care. They are also more likely to be hospitalized during pregnancy, deliver infants with low birth weights, and live with HIV.
- Substance use exists on a spectrum, and people who use drugs may find themselves at different parts of the continuum at different points in their use.
- There is a difference between addiction, dependence, and tolerance.
 - Addiction is a physiological/brain disease that manifests behaviorally. It is characterized by:
 - compulsion to obtain and use a substance
 - loss of control over intake
 - recurrence of a negative emotional state (e.g., dysphoria, anxiety, irritability)
 - Dependence is an adaptation of the body and mind to a specific substance; in the absence of that substance withdrawal syndrome can develop
 - Tolerance occurs when the reaction to or sensation of a certain amount of a substance decreases with repeated use
- **Babies cannot be born addicted to drugs.** The myth that they can was generated at the height of the racist war on drugs which demonized pregnant people who used drugs, Black people. Though babies cannot be born addicted to substances, they can experience two conditions related to their birthing parents' substance use. One is known as neonatal abstinence syndrome (NAS), a phenomenon in which babies are born physically dependent on substances (drugs or alcohol) to which they are exposed in utero. The other is neonatal opioid withdrawal syndrome (NOWS), a phenomenon like NAS but specific to opioid users.
 - Substance exposed newborns may experience withdrawal symptoms once the umbilical cord is cut even if their birthing parent has taken prescription drugs such as methadone or buprenorphine to prevent withdrawal and manage their use.
 - Neonatal abstinence syndrome is a short-term, treatable condition that does not have a lasting impact on an infant's cognitive, psychomotor, or behavioral development.



Guiding Principles

Barriers to care

Pregnant people who use drugs face certain barriers to care which contribute to their morbidity and mortality. This includes:

- **Inadequate social support:** lack of social support prevents many people who use drugs from recognizing their inherent value and voicing their needs.
- **Fear of child protective services (CPS):** fear of criminalization and family separation has a lasting emotional and material impact. It increases the stigma faced by pregnant people who use drugs and prevents them from seeking support from institutions (health and social service providers) and community members.
- **Prior negative experience(s) with health care providers:** people who use drugs often encounter judgement and rudeness from healthcare providers, which in turns leaves them with a negative view of the healthcare field and discourages seeking support in the future.

- **Provider hesitancy:** due to stigma, inadequate training, uncertainty regarding mandated reporting and/or lack of resources, health and social service providers can be hesitant to explicitly name, and address substance use by a pregnant person. Even those who are not judgmental may feel at a loss for what to do and be unclear on how best to provide support.

Social determinants of health

Social determinants of health (SDOHs) such as education level, financial (in)security, environmental factors, zip code, and social connections are factors that greatly influence health outcomes. The impacts of SDOHs are heightened among multiple marginalized populations, including black and indigenous people, migrants, the incarcerated and formerly incarcerated, poor people, and people who use drugs.

Reducing Stigma

The language we use to talk to and about our patients has a large impact on their well-being and the level of satisfaction they feel with care and service provision. As healthcare providers, it is important to recognize that not all pregnant people who use drugs identify as women, nor do all people who can become pregnant, including gender non-conforming and transgender people. It is for that reason that we use gender inclusive language and terms such as “birthing parent” and “pregnant people” instead of “mothers” and “women”.

When in doubt about a patient’s identity, simply ask. This should be done at the first point of contact. When introducing yourself, share your name and what gender pronouns (e.g., they/them, she/her, he/him) you prefer. Then ask the client for their name and preferred gender pronouns. Modeling such language can make your client feel more comfortable, and at the very least will let them know that you are committed to inclusion. Here is an example:

Hello, my name is Mo & I use they/them pronouns. What is your name? What pronouns do you want us to use when referring to you?

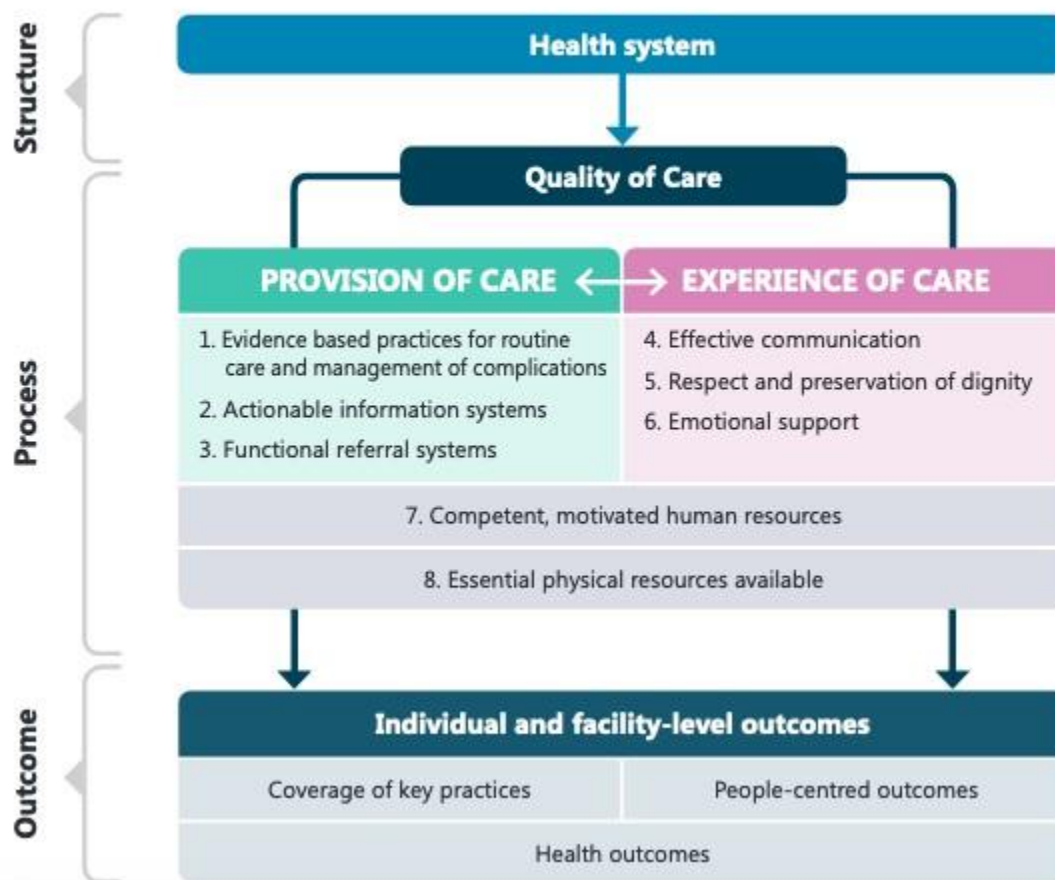
In general, it is best to avoid using stigmatizing language when talking about substance use. Words like “clean”, “addict”, “junkie”, “fiend”, “crackhead”, “crack baby” and so on carry negative connotations that can weaken a client’s self-esteem. It is important to use scientific, value-neutral, person-first terminology to avoid shaming and further stigmatizing your patients. This will show your client that you see, care for and value them as a person, not by their substance use.

Helpful Frameworks

When working with pregnant people who use drugs, it is essential for healthcare providers to treat their clients and patients with compassion and non-judgment in order to provide the highest level of care. You may be unsure of how best to address the needs of a pregnant person who uses drugs. If so, it is important to address your personal thoughts and feelings around drug use and pregnancy, seek out facts supported by rigorous research, and use a person-centered approach. Instead of discouraging conversation about a client’s drug use, seek opportunities to build rapport with clients to encourage trust and a willingness to disclose. This will improve the quality of care provided to your patients and lead to long term, positive change for them and their child.

The World Health Organization (WHO) defines “quality of care” as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes”. WHO provides a framework (Fig. 1) with eight tenets which can be used to assess, improve, and monitor care for birthing parents and their infants in facilities and communities. Providers can make use of this framework in order to provide health care that is safe, effective, timely, efficient, equitable and people centered.

Fig. 1. WHO framework for the quality of maternal and newborn health care



The Substance-Exposed Infants Framework is a five-point intervention developed by the National Center on Substance Abuse and Child Welfare (NCSACW). This framework serves as a model and identifies five major points in time in which intervention can help reduce the potential harm of prenatal substance exposure. These five frames are:

1. **Pre-pregnancy:** Interventions can include promoting awareness among persons of child-bearing age and their family members of the effects that prenatal substance use can have on infants.
2. **Prenatal:** Health care providers can screen pregnant women for substance use as part of routine prenatal care and to make referrals that facilitate access to treatment and related services.
3. **Birth:** Interventions include health care providers treating newborns for prenatal substance exposure at the time of delivery.
4. **Neonatal:** Health care providers can conduct a developmental assessment of the newborn and ensure access to services for the newborn and the family.
5. **Childhood and adolescence:** Interventions include the ongoing provision of coordinated services for both child and family.

Best Practices

Early identification of substance use allows for early intervention and treatment which minimizes potential harm to the birthing parent and baby. Early screening allows practitioners to maximize the motivation for change during their patient's pregnancy. For this reason, screening pregnant people with a combination of validated screening tools at their first point of prenatal care-seeking is vital.

Additionally, screening must be universal, not based solely on appearance, personal bias and poor adherence to prenatal recommendations.

Several tools are shared below in detail. Urine drug testing should never be done without full patient consent. It should not be used as a sole assessment of substance use because:

- It has a short detection window
- It may not capture binge or intermittent use
- It does not capture addiction
- It rarely detects alcohol
- It doesn't always capture prescription opioids
- It can diminish patient trust

As a practitioner, it is important to normalize questions regarding drug use by embedding them in other health behavior questions. One should seek patient permission to ask screening questions, avoid close-ended questions and assure their patient that such questions are asked of all patients. When possible, connect your patient to a local doula (individual or organization). Access to doulas has been demonstrated to improve birth outcomes and disrupt the negative influence of social determinants as predisposing factors for health during pregnancy and childbirth.

Additionally, a harm reduction approach toward pregnant people can have a positive effect. Substance use is one of several factors that impact a pregnancy, and behavioral changes beyond total abstinence are most effective in protecting the birthing parent and baby from harm. Behavioral changes such as reducing the amount or frequency of substance use, using substances more safely and never using alone go a long way in protecting a patient's health. Harm reduction services such as syringe exchange programs, street-based outreach and drop-in services/spaces provide a nonjudgmental, welcoming atmosphere, allowing pregnant people who use drugs to be open about their use, access prenatal care, receive peer support, and deepen social connections.

Medications for Opioid Use Disorder

MOUD is the use of medications, conjunction with behavioral therapy and counseling, to provide comprehensive treatment of SUD and OUD. Methadone and buprenorphine are the safest and most effective medications for OUD in pregnancy. Neither medicine has been associated with birth defects. Methadone has been used since at least the 1970s and buprenorphine since 2002. Both medications can be used in conjunction with behavioral therapy or counseling and are safe and recommended for people with OUD who are breast/chestfeeding. Though breast/chestfeeding is a safe option that should be encouraged for those who are receiving medication for opioid use disorder, it may not be recommended for patients who are positive for HIV for there is the potential to transmit the virus to the newborn. It is recommended that medication for substance use disorders be continued postpartum to reduce the risk of an overdose. Additionally, because addiction is a chronic illness, its medical management should also be chronic.

Buprenorphine

Buprenorphine is taken daily and comes in a few different forms. On its own it is known as Subutex. When combined with naloxone it is known as suboxone. This buprenorphine-naloxone combination comes as a film but can also come as a tablet known as Zubsolv. It is provided at treatment centers or by primary care providers who are approved to prescribe it, making it easier to access than methadone.

Methadone

Methadone is taken daily and most commonly comes in liquid form. It is provided at treatment centers. Methadone has been used for treatment of OUD in pregnancy since the 1970s.

Obtaining an X Waiver

Qualified practitioners can provide buprenorphine for the treatment of opioid use disorders. This can be done upon receipt of a practitioner waiver known as an X waiver. Practitioners must notify SAMHSA's [Center for Substance Abuse Treatment](#) in the [Division of Pharmacologic Therapies](#) of their intent to practice this form of MOUD. The notification of intent (NOI) must be submitted to SAMHSA before dispensing or prescribing treatment medication.

Call SAMHSA at 866-BUP-CSAT (866-287-2728) with any questions. Steps to obtain the X-waiver vary depending on what sort of practitioner you are.

- [Advanced Practice Registered Nurses](#) (NP/CNM/CNS/CRNA)
- [Physicians](#)
- [Physician's Assistants](#)

Recent Practice Guidelines have allowed for an alternative NOI for those seeking to treat up to 30 patients: The customary NOI requires eligible providers to undertake required training activities prior to their application to prescribe buprenorphine; the alternative type of NOI allows those providers who wish to treat up to 30 patients to forego the training requirement, as well as certification to counseling and other ancillary services (i.e., psychosocial services). Practitioners utilizing this training exemption are limited to treating no more than 30 patients at any one time (time spent practicing under this exemption will not qualify the practitioner for a higher patient limit). This exemption applies only to the prescription of Schedule III, IV, and V drugs or combinations of such drugs, covered under the CSA, such as buprenorphine.

Note that training courses are not needed if your facilities serve less than 30 patients, though SAMHSA registration is still required. The Providers Clinical Support System (PCSS) offers [comprehensive guidance](#) on how to obtain an X-waiver based on the provider role you play.

Utilizing Assessment Tools

Screening, Brief Intervention, Referral to Treatment (SBIRT) is a motivational interviewing (MI) method for relatively quick yet comprehensive assessment of the incidence and degree of a patient's substance use/dependence while reducing stigma. It provides an integrated, public health approach to the delivery of brief intervention and treatment services for people with substance use disorders and those at risk of developing such disorders. This includes [Drug Abuse Screening Test](#), [Michigan Alcohol Screening Test](#), National Institute on Drug Abuse [Quick Screen](#), [the 4 Ps](#), and [Car, Relax, Alone, Forget, Friends Trouble](#) for pregnant adolescents. Additional tools can be found here: <https://www.sbirt.care/tools.aspx>.

Other recommended screening instruments specifically for alcohol include the [T-ACE](#) (Tolerance, Annoyance, Cut Down, Eye-Opener) and [TWEAK](#) (Tolerance, Worried, Eye-Opener, Amnesia, K-Cut Down). Along with screening for substance use, it is important to screen pregnant people for other conditions including anemia, potential for birth defects in the fetus, gestational diabetes, HIV/AIDS, pre-eclampsia, and postpartum depression after birth.

Additional Training Materials and Resources

Maryland Partners and Providers

Below is a table of Maryland-based providers. Additional links to provider searches can be found here:

- [Click here](#) for a complete list of Opioid Treatment Providers
- [SAMHSA Treatment Locator](#)
- [Maryland Association for the Treatment of Opioid Dependence](#) Resource Directory
- [Network of Care](#) Community Service Directory
- [MACS for MOMs](#) Providers outside of Baltimore metro area

Provider Name	Address	Phone Number
University of Maryland Methadone Treatment Program	630 W. Fayette Street 1st Floor, West Wing Baltimore, MD, 21201	443-462-3400
University of Maryland Addiction Treatment Center	1001 W. Pratt Street Baltimore, MD, 21223	443-462-3400
University of Maryland Baltimore Washington Medical Group - Obstetrics and Prenatal Services	203 Hospital Drive Suite 308 Glen Burnie, MD, 21061	410-553-8260
B'More for Healthy Babies Initiative		
Baltimore Family Planning & Reproductive Health Services	Druid Family Planning Clinic 1515 W. North Avenue Baltimore, MD 21217	410-396-0185
	Eastern Family Planning Clinic 1200 E. Fayette Street Baltimore, MD 21202	410-396-9401
Maternal and Infant (M&I) Care Program	1200 E. Fayette Street Baltimore, Maryland 21202	410-396-9404
Maryland Maternal and Perinatal Health Program	201 W. Preston Street Baltimore, MD 21201	1-800-456-8900
Center for Addiction and Pregnancy (Johns Hopkins Bayview Medical Center)	4940 Eastern Avenue Baltimore, MD 21224	410-550-3066
SPARC Center	908 Washington Boulevard Baltimore, MD 21230	410-624-7554
Charm City Care Connection	1212 N. Wolfe Street Baltimore, MD, 21213	443-478-3015 (General) 301-615-2193 (Case Management)
BD Health Services	Multiple locations	
Turning Point Clinic	2401 E. North Avenue Baltimore, MD 21213	410-675-2113
Starting Point Clinic	4109 Ritchie Highway Brooklyn Park, MD 21225	410-609-0040
Institutes for Behavior Resources Inc REACH Health Services	2104 Maryland Avenue Baltimore, MD 21218	410-752-6850

Training Materials

Opioid Use

- [Best Practices for Caring for Pregnant and Postpartum Women with Opioid Use Disorder](#)
- [A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders](#)
- [Supporting Pregnant & Postpartum Women \(with SUD\)](#)
- [Discussion Guide: Increase Healthy Start and Home Visiting Staff Knowledge of Opioid Use among Pregnant Women](#)

Alcohol

- [E-Learning Course: Alcohol and Substance-Exposed Pregnancies: A Growing Public Health Problem](#)
- [CDC Training & Resources on Fetal Alcohol Spectrum Disorders \(FASDs\)](#)

Tobacco

- [Training and Resources for Maternity Health Professionals](#)
- [Clinician-Assisted Tobacco Cessation](#)
- [Smoking & Tobacco Use: Education and Training](#)

General

- [Maryland Maternal Health Innovation Program](#)
- [CAPTA & CARA Community Teach-In: Pregnancy, Birthing, Hospitals & Drug Testing](#)
- [State Legislation on Substance Use During Pregnancy: A Self-Study Guide](#)
- [Caring for Transgender and Genderqueer Clients with Cultural Humility](#)
- [LGBTQIA+ Health Education Center](#)
- [Treating Women for Opioid Use Disorder during Pregnancy: Clinical Challenges](#)
- [Interactive E-Learning Module for Providers Caring for Pregnant Women on Screening, Brief Intervention, and Referral to Treatment](#)

Web-based SBIRT trainings

- [A Brief Intervention to Help Patients Quit Smoking](#)
- [Introduction to Motivational Interviewing](#)
- [Motivational Interviewing, Tobacco Interventions & SBIRT Core Activities](#)
- [Blending Initiative Motivational Interviewing CME/CE and Patient Simulation](#)

Resources

- [Opioid Use and Opioid Use Disorder in Pregnancy](#)
- [Pregnancy & Substance Use: A Harm Reduction Toolkit](#)
- [Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants](#)
- [Expecting Better: Improving Health and Rights for Pregnant Women Who Use Drugs](#)
- [Treating Opioid Use Disorder During Pregnancy](#)
- [Medications to Treat Opioid Use During Pregnancy – An info sheet for providers](#)
- [Pregnancy: Methadone and Buprenorphine](#)
- [Providers' Clinical Support System for Medication Assisted Treatment](#)
- [National Center on Substance Abuse and Child Welfare \(NCSACW\)](#)
- [Treating Women for Opioid Use During Pregnancy](#)
- [Treating Opioid Use Disorder During Pregnancy](#)
- [A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders](#)
- [Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome](#)
- [Treating Babies Who Were Exposed to Opioids Before Birth](#)
- [Substance Use and Medication Safety](#)
- [Maryland Prenatal Risk Assessment](#)
- [Medication for the Treatment of Alcohol Use Disorder: A Brief Guide](#)
- [Alcohol Screening & Brief Intervention of Youth: A Practitioners Guide](#)
- [Neonatal Abstinence Syndrome \(video\)](#)
- [Substance Use Prevention, Screening, Education, and Referral Resource Guide for Local WIC Agencies*](#)
- [Finding Quality Treatment for Substance Use Disorders*](#)
- [*These documents contain language that is outdated.](#)

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