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The Massachusetts Department of Public Health Post Overdose Support Team Initiative: A Public Health–Centered Co-Response Model for Post–Overdose Outreach

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ABSTRACT

Context: Post–overdose outreach programs have emerged in response to surging overdose deaths amid fentanyl contamination of the illicit opioid supply. Predominantly centered in police departments in collaboration with public health providers, these programs conduct home-based outreach with survivors and their social networks following an overdose.

Approach: We describe implementation of the Post Overdose Support Team (POST) initiative, an ongoing public health funded and centered approach. Post Overdose Support Team is a person-centered model led by harm reductionists in health and human services agencies in collaboration with municipal first responders. The goal of POST is to engage overdose survivors and their social network to improve general health, connect people to services (including access to treatment, if desired), and reduce risk of subsequent overdose.

Implementation: Nine agencies in Massachusetts that are part of the state's overdose education and naloxone distribution network implemented POST programs, covering 28 municipalities. The POST teams conduct home-based outreach with individuals who experienced an opioid-related overdose to provide a menu of services, including naloxone rescue kits, overdose response and risk reduction planning, referral to treatment for substance use disorders, including medication for opioid use disorder, and referral to recovery and family supports.

Evaluation: From October 2017 to October 2021, the POST teams attempted to reach 5634 overdose survivors via 10 536 outreach visits. Teams successfully engaged 3014 survivors, either directly or through contact with their social network (53.5% success rate). Using data from a real-time encounter-level database, monthly peer-sharing calls with program sites, and annual site visits, we describe the implementation of the POST initiative and provide practice-based recommendations and lessons learned.

Discussion: Early evidence suggests that the POST initiative is meeting its goal to engage overdose survivors, improve general health, and reduce subsequent overdose risk. Future evaluations should examine long-term outcomes among participants, including service linkages and incremental behavior change.

KEY WORDS: harm reduction, opioid overdose, post–overdose outreach, public health

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Context

Drug overdose events, both fatal and nonfatal, continue to impact municipalities throughout the United States. Provisional estimates from the Centers for Disease Control and Prevention indicate more than 100 000 drug overdose deaths between May 2020 and April 2021, largely attributed to the convergence of the COVID-19 pandemic, expansion of illicit fentanyl and fentanyl analogs in the US drug supply, and intentional and unintentional polysubstance use of psychostimulants (cocaine, crack, methamphetamine) with opioids and illicit synthetics.[1,2] Given that nonfatal drug overdose is associated with increased risk for subsequent overdose,[3,4] there has been increased interest in developing and implementing post–overdose interventions in emergency department and community settings.[5,6] In late 2015, members of our study team were among the first to describe the organic emergence of collaborative efforts between public health and public safety agencies in Massachusetts to conduct home-based outreach with overdose survivors and their personal networks soon after an overdose event.[7] We identified post–overdose outreach programs in 23 municipalities—predominantly initiated by and centered within police departments. In these models, police departments were primarily responsible for structuring, organizing, coordinating, financially supporting, and retaining decision-making power over their operation. Based, in part, on the findings from this study, state public health planners began conceptualizing what such a program might look like if it were initiated by and centered within health and human services agencies.

In May 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched a 2-year State Targeted Response to the Opioid Crisis (STR) grant to increase access to medication for opioid use disorder (MOUD), reduce unmet treatment need, and reduce fatal opioid overdose through the implementation of prevention, treatment, and recovery services.[8] The SAMHSA subsequently enhanced and extended these efforts through the State Opioid Response (SOR) grant. In Massachusetts, the Bureau of Substance Addiction Services (BSAS) in the Department of Public Health used STR/SOR funding to develop the Post Overdose Support Team (POST) initiative—a multisite demonstration project to support locally designed harm reduction–oriented outreach following an overdose event.

The primary goal of POST is to reduce the risk and severity of opioid overdose via a supportive, informational encounter with individuals who have overdosed and/or their social network. The focus of these encounters is on the safety of the person who overdosed and on providing overdose prevention education, referrals, and resources in a manner that is person-centered, responsive, confidential, nonconfrontational, and grounded in harm reduction principles. In contrast to the growing number of post–overdose outreach models that are centered in police departments,[5,6,9] the POST initiative directed funding and decision-making power to health and human services agencies serving people who use drugs (PWUD). The rationale for this approach was based on the desire to (1) increase receptivity among PWUD by minimizing involvement of representatives from the criminal legal system in a public health outreach visit, with input on the nature and parameters of their involvement; (2) support access to and engagement in a full range of harm reduction education and resources, including treatment and recovery support options and support for safer drug use practices, based on different levels of readiness for change[10]; (3) design an approach that would not have a chilling effect on the propensity of bystanders at an overdose to call for emergency assistance[11,12]; and (4) enhance engagement with overdose survivors and other individuals not already known to and utilizing community-based harm reduction and overdose prevention services.

The aim of this practice report is to describe the design, early implementation, and evolution of the POST initiative in Massachusetts between October 2017 and October 2021 from the experience and perspectives of program staff. We draw on data from grants management records, a real-time encounter-level database of all outreach attempts and visits hosted in REDCap,[13] monthly peer-sharing calls with program staff, and annual site visit interview data from each implementing site. We conclude by offering lessons for practice for those currently implementing or planning to implement similar models.

Approach

POST initiative model

In June 2017, BSAS issued a competitive request for response to solicit applications from health and human service agencies in Massachusetts—including the state's syringe services programs and other agencies specializing in the provision of health services for PWUDs, naloxone, and access to substance use treatment and case management.[14] Ten agencies applied and 3 were initially awarded funding. Preference was given to agencies that had existing partnerships with first responders (police, fire, and/or emergency medical services [EMS]) and at least 1 year of experience conducting community outreach with PWUDs. The BSAS convened these programs into a learning

collaborative that met monthly. Through consensus among the funded agencies and the team at BSAS, the following features of the program were developed.

Creation of a post–overdose response team

Funded sites planned to develop or enhance an existing post–overdose response team comprising harm reduction specialists and first responders. The rationale for this decision was that first responders, commonly police, have information from 911 emergency response calls that can be used to identify suspected opioid-related overdose events. Through the establishment of formal and informal data-sharing agreements, including consideration of HIPPA/42CFR Part 2 regulations when applicable, this information can be used to identify overdose survivors who may not otherwise seek care on their own—including those who refuse transport to emergency departments following an overdose event and those who are not offered or interested in services prior to discharge from an ED.

Based on local considerations, some sites planned to add additional partners to the post–overdose support team but intended to limit the team to at least 2, but no more than 3, members on a given outreach visit. During the team formation stage, sites planned to establish formal or informal memoranda of agreement with their partnering agencies that outlined roles and expectations. Members of the learning collaborative indicated that an individual's participation on the outreach team should be voluntary and that teams should attempt to include members that reflected the gender, race, ethnic, cultural, and linguistic tapestry of the community. Sites anticipated that team members would receive regular supervision and support within their agency and have the skills to communicate with community members in a respectful and supportive manner. When feasible, sites planned to identify and train multiple individuals to allow for rotating outreach schedules and to reduce burden on team members. Sites also planned to provide training to their partner first responder agencies, as needed, on topics such as procedures for engaging with overdose survivors and their social networks, harm reduction, stages of change, overdose prevention, and navigating the addiction treatment system.

Survivor identification and outreach preplanning meetings

As part of the data-sharing agreements with first responder agencies, all emergency 911 calls were to be screened for suspected opioid-related overdose events—determined by the administration of naloxone by responding personnel and additional notes from police, fire, or EMS personnel indicating a suspected overdose. These records were also to serve as the source of information on the address of the survivor and/or the location of the suspected overdose event. In advance of conducting outreach, teams planned to review opioid-related 911 calls and identify which addresses and locations to visit. Teams intended to attempt outreach at the last known residence of the survivor and/or the location of the overdose event (eg, private residences, businesses, motels, encampments for persons experiencing homelessness). As part of this process, teams identified the importance of attempting to confirm the status of the individual who overdosed, particularly whether the overdose resulted in a fatality—which might influence decisions about whether to proceed with the visit. Members of the learning collaborative decided that teams should attempt to conduct outreach with all overdose survivors identified, but that teams should have discretion on the final determination, based on consensus, of whether to conduct an outreach visit based on factors such as the overdose survivor's history, circumstances surrounding the overdose event, perceived safety of the location, and other considerations that might result in unintentional harms to the overdose survivor or members of the outreach team. In these instances, outreach might be deferred to a later date, the record might be forwarded to another agency/provider, or no additional action might be taken on the basis of the unique characteristics of each situation.

Outreach and wellness checks

Depending on the number of overdoses in each community, teams planned to conduct in-person outreach at least once or twice a week. If teams were not able to contact the overdose survivor or a social network member during the first outreach attempt, they would attempt a second visit. If teams contacted the survivor, they planned to approach the individual in a nonconfrontational and confidential manner, introduce the outreach team and the goals of the visit, and offer nonclinical support services and referrals based on the individual's interest in available services. The menu of available services for overdose survivors was to include (*a*) education on overdose prevention, recognition, and response; (*b*) overdose risk reduction planning; (*c*) harm reduction supplies such as syringes and naloxone; (*d*) referrals to local harm reduction programs or addiction treatment programs (including detoxification, MOUD, and other recovery supports); and (*e*) assistance accessing social services (employment, food, housing). If the overdose survivor accepted services, teams would decide on the extent

and duration of additional follow-up contact, based on the desires and needs of the individual.

If teams encountered a social network member of the overdose survivor during the outreach attempt and were not able to directly contact the overdose survivor, they would exercise discretion to engage with this individual. In such instances, teams would work to maintain the confidentiality of the overdose survivor and not disclose any information or specifics that were not already known to these individuals. Teams planned to offer social network members a similar menu of services as overdose survivors, including family and child resources and referrals, as appropriate. Teams were also prepared to offer bereavement, trauma, and grief support services or referrals if they opted to conduct outreach following a known fatal overdose or an overdose with an unknown outcome.

Implementation and Evaluation

POST sites, team composition, and planning

This article covers the early implementation period of the POST initiative from inception in October 2017 through October 2021. The BSAS initially funded 3 health and human services agencies in October 2017 to implement the POST model. These agencies had extensive experience serving PWUDs and were each part of the state's existing overdose education and naloxone distribution network. Four additional sites were added in November 2018, and 2 more in July 2019. These 9 sites implemented the POST model in 28 municipalities (range: 1-7 municipalities per site; median: 3). As of the 2020 census, the median population in municipalities served by a POST program was 39 644 people. Across all municipalities, 53% of residents were non-Hispanic White, 20% were Hispanic or Latinx, 11% were non-Hispanic Black, 9% were Non-Hispanic Asian, and 7% were multiracial or another race. Estimates from the Massachusetts Ambulance Trip Record Information System (MATRIS) indicate that there were a median of 104 ambulance encounters per year in 2019-2020 in each of these municipalities that were recorded as a suspected overdose. Data from the Massachusetts Registry of Vital Records and Statistics indicate that there were a median of 12 overdose fatalities per year in 2018-2020 in each of these municipalities.

Across the 28 municipalities, the outreach team ranged in size from 2 to 4 individuals. All were staffed by harm reduction specialists. Additional team members included police (93% of municipalities), fire fighters (18%), recovery coaches (11%), public health nurses (11%), social workers (7%), and multifaith clergy members (7%). The most common team configurations were a harm reduction specialist paired with a police officer (39% of municipalities) and a harm reduction specialist and police officer paired with an additional team member (36%).

The primary source of information on overdose events and survivors came from police emergency call data (82% of municipalities) and from fire department/EMS call data (18%). Information shared with the team generally consisted of the survivor's name, phone number, reporting party, address, disposition, and notes about the incident. All municipalities that received data from the police indicated that the police checked for active arrest warrants prior to outreach. If the situation was deemed unsafe or if police felt that execution of the warrant needed to be prioritized before outreach, teams either did not conduct an outreach visit or did not conduct an outreach visit until after the warrant had been cleared. In a subset of municipalities (25%), police did not go on the outreach visit if there was an active warrant but provided contact information to the harm reduction specialists when the nature of the warrant did not suggest a danger to team members.

POST outreach and wellness checks

Depending on the size of the municipality and the number of overdose events, teams were split between conducting visits on a set schedule (46% of municipalities) versus waiting for a threshold number of events (54%). Sites with a set schedule tended to conduct visits on Tuesdays and Thursdays during early afternoon and evening hours. Teams commonly convened at the public safety partner's agency to review the list of overdose events and to determine which individuals to attempt to reach. Teams often traveled together in the same vehicle and attempted to visit multiple overdose survivors during each outing. The COVID-19 pandemic resulted in adjustments to outreach procedures to protect team members and individuals they encountered (eg, traveling in separate vehicles, meeting outside, distributing personal protective equipment).

Between October 2017 and October 2021, POST teams identified 6311 unique individuals who experienced an overdose and attempted to reach 5634 of these individuals (89.3%). The most common reasons for not attempting to conduct outreach were insufficient or faulty contact information or the individual living outside of the program's catchment area (ie, overdosed in a POST municipality but resided elsewhere). Most initial outreach attempts (83.1%) were conducted within 14 days of the overdose event. Teams successfully engaged 3014 overdose survivors (53.5% of those identified) either directly or indirectly

TABLE 1
Services Delivered to Overdose Survivors and Social Network Members by POST Teams[a]

	Survivor Visits (n = 2409)		Network Visits (n = 1998)	
Service	**n**	**%**	**n**	**%**
Overdose prevention education	1612	66.9	1033	51.7
Overdose risk reduction planning	1418	58.9	647	32.4
Naloxone enrollment/refill	1218	50.6	1017	50.9
Safe drug use supplies	236	9.8	44	2.2
Referral to syringe access services	307	12.7	46	2.3
Referral to case management services	310	12.9	154	7.7
Referral to detoxification facility	357	14.8	89	4.5
Referral to medication for opioid use disorder	347	14.4	89	4.5
Referral to family supports	231	9.6	693	34.7
Referral to recovery supports	862	35.8	416	20.8
Referral to bereavement supports	29	1.2	28	1.4

[a] *The survivor visits column is inclusive of any visits during which the survivor was present, independent of whether other individuals were also present. The network visits column is exclusive of the survivor being present.*

through their social network. Teams were not able to locate 2359 survivors (41.9%)—mostly due to the survivor not being home at the time of the outreach visit, not having access to the location (eg, apartment building), or inaccurate addresses. The remaining 216 overdose survivors (4.6%) were reached but declined to engage with the team. Teams conducted an average of 1.49 attempts before removing survivors from the contact list.

Overall, teams conducted 10 536 outreach attempts (a median of 16 attempts per community per month while the program was in operation in the municipality), 4407 of which (41.8%) resulted in engaging with an overdose survivor or social network member. Teams were most likely to provide overdose prevention education (60.0% of visits), naloxone (50.7%), and overdose risk reduction planning (46.9%) during all visits. Visits that included only social network members were more likely to cover referral to family supports. Visits with survivors present were more likely to cover referral to recovery supports (Table 1). Throughout the study period, most overdose survivors (79.5%) had only 1 encounter with the POST team. A social network member was present (either with or without the survivor) during 56.7% of all visits.

Perceived outcomes among program staff

Across all visits, POST team members were asked to rate the receptiveness of individuals they encountered. Staff reported that contacts were somewhat, mostly, or very receptive during most visits (88.1% combined). When asked what they felt was the outcome [of] each visit, POST staff were most likely to indicate that they increased knowledge of overdose prevention, reduced stigma of PWUDs, increased knowledge of available supports and resources, and increased access to naloxone (Table 2).

Practice-based lessons learned

Project directors and front-line harm reductionists across the 9 POST sites participated in monthly peer-sharing calls and annual site visits. The following practice-based lessons learned were thematically extracted from notes and recordings from these meetings and visits.

Creation of a post–overdose response team

The POST sites universally indicated that the optimal size of outreach teams for any given visit was 2 to 3 individuals—observing that having 4 or more individuals standing on a doorstep ("flooding the porch") can be overwhelming and counter-productive. Sites also reiterated the importance of having gender and racial/ethnic diversity within teams that matched the characteristics of the community and having access to multilingual staff fluent in Spanish, Portuguese, or other common world languages represented in areas of focus. Optimally, sites recommended having at least 1 male and 1 female present on each outreach visit.

When developing and staffing the team, sites emphasized the importance of having clarity of purpose. Specifically, sites reflected on how different team members may have different personal goals for any given visit, including engaging with PWUD,

TABLE 2
Perceived Outcomes Among Program Staff of Services Delivered to Overdose Survivors and Social Network Members[a]

	Survivor Visits (n = 1655)		Network Visits (n = 1258)	
Perceived Outcomes	**n**	**%**	**n**	**%**
Increased knowledge of overdose prevention	1113	67.3	749	59.5
Reduced stigma	973	58.8	844	67.1
Increased knowledge of support and resources	1329	80.3	960	76.3
Increased access to naloxone	1082	65.4	847	67.3
Enhanced overdose risk reduction plan	436	26.3	225	17.9
Increased access to harm reduction supplies	442	26.7	193	15.3
Enhanced capacity to act during an overdose	499	30.2	523	41.6
Increased receptiveness to access services	637	38.5	307	24.4
Decreased overdose risk factors	460	27.8	206	16.4
Decreased risk of fatality	590	35.6	328	26.1

[a] *The survivor visits column is inclusive of any visits during which the survivor was present, independent of whether other individuals were also present. The network visits column is exclusive of the survivor being present.*

promoting safer drug use practices, endorsing abstinence, making linkages to treatment, and/or supporting recovery. Sites valued the diversity of perspectives that different team members may bring but discussed the importance of overdose survivor-driven goals and cautioned against rigid or overzealous team members forcing their personal goals on others.

Teams that included police during outreach visits identified wide variation in their role and level of involvement both within teams and across municipalities. This ranged from officers going into residences and actively engaging with people to offer support to standing back and just "making sure nothing bad happens." All sites discussed the difficulty of finding police who are suited for this type of work and noted the importance of interviewing prospective team members. Sites also emphasized the importance of having direct access to a supervisor or chief to whom they can provide critical feedback, recommend staffing changes, or modify or terminate existing arrangements. Sites reiterated the need to provide or make available training to officers.

Reflecting more globally on partnering with police departments, sites universally identified access to overdose event emergency call data as a critical and driving factor for their involvement. Most sites reported that they would not be given access to these data if police officers were not also part of the outreach team. In general, sites reported that police involvement could be an asset. Similarly, most sites reported that they felt that supervisors and chiefs were receptive to feedback and had made recommended changes or reassignments, as needed. A subset of sites discussed feeling that participation in POST had resulted in changing police attitudes about and humanizing PWUDs. However, sites were nearly unanimous in their perspective that police do not need to attend every outreach visit, with some suggesting that the health and human service agency should have the option to determine when to have a police officer (or other public safety representative) on an outreach visit.

Survivor identification and outreach preplanning meetings

Sites identified the importance of planning meetings before conducting outreach visits—ideally having an opportunity for the team to review records and discuss each case at the outset of the day's outreach activities. In practice, many sites reported that preplanning takes place informally during car rides. Sites described the need to be aware of contextual factors for certain addresses (eg, recent drug raid, residence of concern) and when determining who attends the outreach visit (eg, not retraumatizing people if a team member also attended the overdose event, being sensitive to fear of police or eviction). A recurring challenge across sites was the unreliable quality of contact information collected by attending first responders at the overdose event—including missing phone, apartment, or building numbers. Most sites expressed interest in attempting to make phone contact with overdose survivors prior to the outreach visit, particularly as a COVID-19 precaution. However, many reported that this was largely unsuccessful, due to calls going directly to voice mail, phone lines being discontinued, and wrong or no numbers being listed in the case report. Sites also described the importance of having clearly defined rules concerning whether and when warrant checks will be conducted by police partners

and the resulting action based on the findings. Sites adamantly emphasized not conflating post–overdose outreach visits with the criminal legal system.

Outreach and wellness checks

When conducting outreach visits, sites emphasized the importance of discretion and not drawing unnecessary attention to individuals or locations. Concrete steps recommended by sites included all team members wearing plain clothes versus occupational uniforms, conducting visits in unmarked vehicles, and not parking directly in front of the residence. Sites recommended deciding ahead of time which team member will knock on the door, not knocking aggressively, and being sensitive to not breaching confidentiality during outreach attempts. Specifically, sites recommended asking permission to engage in discussion, expressing gratitude for answering the door, introducing the team members, providing identification if requested, and leading with broad language such as, "we are following up on a medical incident" or "we are doing a well-being check." Sites recommended not directly mentioning overdose before being prompted and engaging only those individuals who volunteer knowledge of the overdose event. If overdose was not mentioned by the individual answering the door, sites emphasized the importance of having an exit strategy (eg, "we must have the wrong house," "our information is not always accurate"). Sites also emphasized the importance of private discussions and awareness that some PWUDs may not be willing to talk openly about their drug use or to accept safer drug use supplies when a public safety representative or family member is present.

Although all sites provided services to social network members, teams tended to recommend making referrals for family and child supports so that the focus of the outreach team could remain on the overdose survivor. When engaging with family members specifically, sites noted that family might bring up involuntary civil commitment to treatment for substance use disorder. Teams universally regarded this as an option of last resort and recommended educating family members who ask about involuntary civil commitment on its potential for harm and referring these individuals outside of the team for those who want to pursue a petition to commit.

If teams were not able to reach the overdose survivor and the person whom they encountered had no knowledge of the overdose event, sites recommended discretely leaving behind their contact information. Sites indicated that this should be nondescript and not refer to drug use or overdose on the contact card or in the person's job title. If teams did not contact anyone during the outreach attempt, some endorsed leaving contact information if it could be left privately (eg, in a sealed envelope or in a mailbox without referencing drug use or overdose).

Discussion

Post–overdose outreach models have expanded with little information to guide their development and operation and a dearth of evidence on their effectiveness. Although it is not uncommon for implementation to outpace science for innovative programs that emerge in response to urgent need, the existing literature provides few details on how municipalities have chosen to design these programs and early lessons derived from the wisdom of practice. The goal of the POST initiative is to engage overdose survivors and their social network to improve general health, connect people to services, and reduce risk of subsequent overdose. During its first 4 years of implementation, the POST initiative demonstration project was successful in conducting more than 10 000 post–overdose outreach visits and engaging more than 3000 overdose survivors either directly or indirectly through a social network member—more than half of those they attempted to contact. These contacts represent opportunities that might not otherwise occur to bring the offer of supports and services to individuals who are not already aware of, connected to, or comfortable accessing these services on their own. Although these programs made referrals to a wide range of treatment and recovery supports, the most common services requested/provided were overdose prevention education, overdose risk reduction planning, and naloxone enrollment and refill. This is consistent with the initiative's goal to improve general health and to reduce risk of subsequent overdose through incremental positive change. The next phase of the evaluation is in the process of examining whether referrals to services for those who request them result in successful connections, and whether there are longer-term changes in overdose risk reduction actions, service utilization, and recent substance use.

Following postoverdose coresponder models that have largely emerged out of police departments,[5,6,9] the POST initiative demonstrates the feasibility of embedding these programs within existing public health infrastructure (eg, health departments, health and human services agencies). A relatively unique aspect of the POST initiative is its requirement to staff outreach programs with at least 1 harm reduction specialist. Although the days following a nonfatal overdose offer a unique opportunity to engage survivors,[15] it does not necessarily mean that these individuals are ready to accept services or to curtail their drug use. The

presence of harm reduction specialists facilitates the provision of a full range of prevention, treatment, and recovery support options, including support for safer drug use practices, based on different levels of readiness for change and can help PWUDs redefine what success means based on the harm reduction principle of any positive change.[16] The presence of harm reduction practitioners may help destigmatize PWUDs—a core principle of the philosophy driven by acceptance, nonjudgmentalism, and attempting to restore autonomy and agency.[10] Reducing stigma was one of the more common outcomes perceived by staff members—particularly during visits in which social network members were present.

As post–overdose outreach models continue to grow, critical questions remain concerning the role and participation of the law enforcement community—including whether law enforcement participation helps further the goals of a harm reduction-oriented encounter or has a chilling effect on the propensity of PWUDs to fully engage in and accept services. Although POST sites that partnered with police departments reported that police participation can be an asset, it does not necessarily mean that this is an optimal or desired approach. Concerns have been raised, for example, about warrant checking practices[17] and other blending of the criminal legal system during a public health outreach visit.[18] The POST sites reported feeling that there were many times when police were not needed as part of an outreach visit but felt that they would not receive contact information data if police were not on the visit. Although emergency call data from police are convenient because they are not considered protected health information in the United States, it may be worth considering alternative or supplemental sources of data from other avenues such as EMS first responders[19] or emergency departments[20] despite the added logistical barriers.

The POST initiative has served to help identify several areas for improvement and enhancement, some of which have already been initiated. These include consideration of broadening post–overdose initiatives to include stimulant-related overdose (overamping),[21] establishing a more formal system of training and technical assistance, better engaging Black and Latinx individuals who use drugs to reduce disparities in overdose demographic trends, developing an advisory group of overdose survivors and family members,[22] and pursuing enhanced supports for family members since they are so frequently encountered during outreach.

The practice-based lessons presented in this article represent the experiences of a small number of programs in a single state and may not be fully generalizable to other settings. In particular, the design of the POST model was made possible by the presence of strong harm reduction infrastructure through the state's existing syringe services programs and overdose education and naloxone distribution programs and may not be feasible on this level in other locations. The findings were limited in that we did not incorporate directly the voices and perspectives of overdose survivors or their social networks on the POST model for this description. This remains an important step in understanding how to improve these programs.

As post–overdose outreach models continue to expand and grow, it is imperative that lessons learned from early adopters help inform the design of new programs and modification of existing programs to maximize public health outcomes. The POST initiative represents an alternative organizational and operational approach that departs in important ways from the law enforcement-centered model for these programs in the United States. Further evaluation is needed to identify best practices and to corroborate or call into question the way existing post–overdose outreach programs have been formed and operate.

Implications for Policy & Practice

- Post–overdose outreach programs can assist in the identification of hidden populations and individuals who may not already be connected to or known to health and human services agencies to engage these individuals and offer supports and services.
- The POST initiative demonstrates the feasibility of embedding post–overdose outreach within existing public health infrastructure as a medical and behavioral health emergency versus centering post–overdose outreach within criminal legal systems.
- The use of harm reduction specialists to staff post–overdose outreach programs brings to bear a full continuum of supports and services beyond abstinence- and treatment-based approaches in a person-centered, nonjudgmental manner that may serve to increase engagement with PWUDs at different levels of readiness to change.

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