

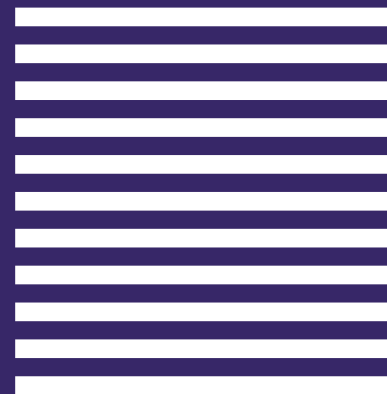


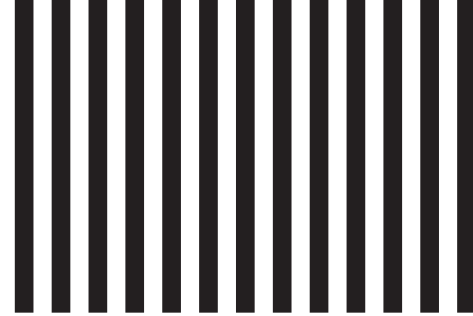
# Street and Mobile Outreach

## Technical Assistance and Training Guide

For Dual-Certified Peer Recovery Specialists, Community Health Workers and Other  
Healthcare Professionals Working to Minimize Drug Overdose Deaths

August 2021

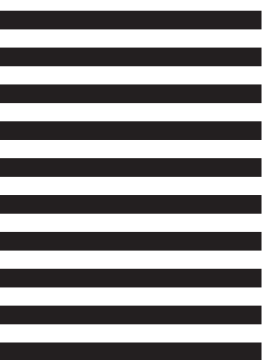




## This guide was developed by Parent Support Network of Rhode Island.

Rhode Island has experienced a 60% increase in all-drug fatal overdoses between 2014 and 2020, despite some years of decreasing counts. This guide is intended to provide recommendations and resources to healthcare professionals who wish to provide mobile recovery support services with an emphasis on targeted populations. In an effort to decrease fatal drug overdoses and increase access to treatment and recovery support services, it is imperative to mobilize treatment and recovery support services.

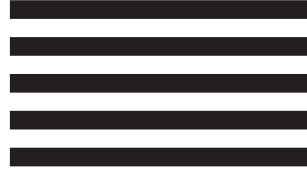
We wish to acknowledge a special thank you to the Rhode Island Governor's Overdose Prevention and Intervention Task Force, the Task Force Work Groups, the Rhode Island Department of Health, and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).





# Table of Contents

- 1. What is Mobile Street Outreach?**
  - a. Definition of street outreach
  - b. What is a Community Health Worker (CHW)?
  - c. What is a Certified Peer Recovery Specialist (CPRS)?
- 2. Who to Outreach**
  - a. Populations Served
  - b. Cultural Considerations
- 3. How to Outreach**
  - a. Roles and Responsibilities
  - b. Services Provided
  - c. Evidence-based Engagement Techniques
- 4. Where to Outreach**
  - a. State Targeted Response
  - b. Community Informed Efforts
- 5. Harm Reduction Approach**
  - a. Principles
  - b. Naloxone and Overdose Prevention
  - c. Needle Exchange
- 6. Safety and Policies**
  - a. Outreach Shift Guidelines
  - b. Transportation Guidelines
  - c. Needle Exchange Policies
- 7. Programmatic Support**
  - a. Structure of Supervision
  - b. Ethical Considerations
  - c. Identify Barriers
- 8. Successful Outcomes**
  - a. Data Collection
  - b. Sharing Personal Stories
  - c. Recovery
  - d. Conclusion
- 9. References**
- 10. Appendix**
  - COVID-19 Best Practices and Response
  - CDC Guidelines
  - Mobile Outreach Recommendations
  - Data Collection Sheet



# CHAPTER ONE

## What is Mobile Street Outreach?

### Learning Objectives:

- Fundamentally understand mobile outreach work
- Understand why mobile outreach is a vital service
- Recommended professional certifications



# **What is Mobile Street Outreach?**

# MOBILE STREET OUTREACH

Mobile outreach programs are designed to engage people who are at-risk for drug overdose. Services can be offered in non-traditional settings such as campsites, public parks, libraries, bus or train stations, exit or entrance ramps to roads and highways, abandoned buildings, or under bridges. Outreach workers may also engage people at local basic needs organizations such as community meal sites, soup kitchens, or clothing centers. Outreach services can benefit individuals who do not have access to transportation. Outreach programs serve as the front door to connect unsheltered or unstably housed individuals to homeless and permanent housing services, treatment programs and harm-reduction resources.

Effective mobile outreach programs connect ignored or underserved people with emergency services, longer-term mental and physical health services, addiction and treatment resources, permanent housing and infectious disease screening. Mobile outreach also helps to re-integrate unsheltered individuals and families into the larger community. Outreach programs should meet people where they are, both geographically and emotionally. This

means meeting people in locations that are most convenient for them as well as developing trusting relationships with people through active listening, persistence, consistency, and without judgment. Because outreach happens in non-traditional settings with people who often have complex needs, outreach workers face challenges that require special skills to do their job well.

Engaging people on their "turf" means outreach workers must be able to maintain personal safety as well as the safety of their clients. Outreach workers must possess and maintain strong ethics, personal boundaries and healthy coping skills while working under very challenging and often stressful circumstances. Outreach workers must make frequent judgment calls about balancing safety and ethics with clients' needs.

A main component of mobile outreach work is to provide basic needs, harm-reduction tools, and peer recovery support to vulnerable populations that often have little or no access to services, including people who are living in urban, rural, and suburban settings.

For instance, mobile street outreach programs provide necessary supplies for people who are living unsheltered and connect people to emergency shelters, especially during very cold or hot times of the year.

Special considerations are needed for mobile teams reaching out to individuals in rural or non-urban areas. Outreach in these areas require additional planning and time to adequately engage target populations. To provide effective street outreach in rural or non-urban areas, it is essential to: create known locations lists that can be updated over time, regularly engage community providers (including law enforcement and other city and county departments that encounter housing insecure people), while creatively including homeless and formerly homeless individuals in the process.

## Street outreach workers are also well positioned to act as advocates for the people they serve.

**This includes advocating for systemic policy change, regulatory considerations and funding needs <sup>1</sup>.**



# What is a Community Health Worker?

## COMMUNITY HEALTH WORKERS

**Community Health Workers (CHW)** are frontline, public health professionals who often have similar cultural beliefs, chronic health conditions, disabilities, or life experiences as other people in the same community. As trusted leaders, they serve as a link between their communities and needed health or social services. CHWs help to improve access to, quality of, and cultural responsiveness of service providers.

CHWs can benefit from a Peer Recovery Specialist certification to become familiar with Rhode Island's healthcare system, social and environmental determinants of health, and behavioral strategies to help community members make healthier choices<sup>2</sup>.

CHWs bring valuable lived experience and an understanding of the specific needs of a community to their work. Similarly, the 15 Rhode Island Health Equity Zones (HEZ) work to address the needs of communities, as defined by the communities themselves. Community-building and understanding is critical to successful outreach efforts.

The Rhode Island Certification Board certifies CHWs and requires certification renewal every two years. The initial application includes requirements, including: 70 hours of training, 50 hours of supervision, a portfolio submission, and an application fee.

More information can be found on

<http://chwari.org>.



# What is a Certified Peer Recovery Specialist?

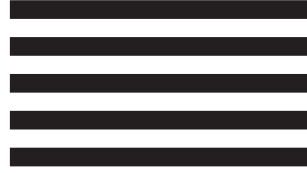
## CERTIFIED PEER RECOVERY SPECIALIST

**Certified Peer Recovery Specialists (CPRS)** (also called "Recovery Coaches") are current or former consumers of behavioral health services who are trained and certified to offer community-integration support to people in the recovery. **Peer Support Services (PSS)** are specialized, therapeutic interactions between peers and individuals in the process of recovery. William White, a renowned recovery literature author, defines a Peer Recovery Coach as "a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community, and serves as a personal guide and mentor in the management of personal and family recovery. Such supports are generated by mobilizing resources within the recovery community or provided by a recovery coach where such natural support networks are lacking."

Peer support is intended to inspire hope in individuals that recovery is not only possible, but *probable*. The service is designed to promote empowerment, self-determination, understanding, coping skills, and resiliency through mentoring and service coordination supports. CPRS work in a wide range of settings including community mental health centers, behavioral health programs, substance use treatment facilities, peer-run and/or community-based organizations, emergency rooms, courts, homeless shelters and outreach programs.

This certification can be obtained through the Rhode Island Certification board. Requirements include but are not limited to 500 hours of working or volunteering as a peer, 46 hours of education and a written examination. More information can be found at

<https://www.ricertboard.org/certifications>



# CHAPTER TWO

## WHO TO OUTREACH

### Learning Objectives:

- Understand what makes a person at-risk
- Learn how to identify the needs of at-risk populations
- Comprehend the dynamics of cultural barriers

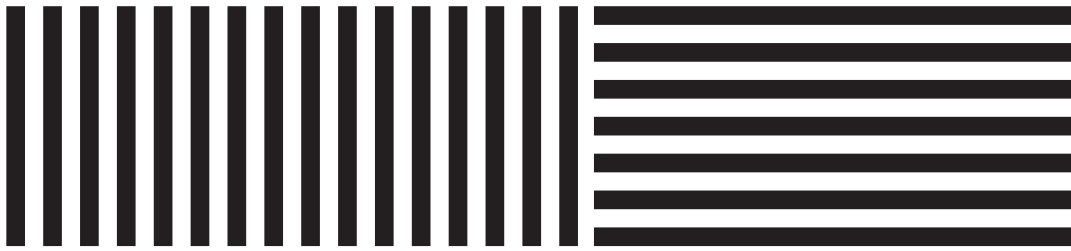
# Populations Served

By mobilizing outreach services, providers are able to bring resources to the geographic locations and the target populations where and when they are needed. The target populations usually consist of individuals who fall through the cracks of traditional services and systems.

Often times, this includes individuals who are homeless or housing insecure. In a study in Western societies, housing insecure persons have a higher prevalence of mental illness when compared to the general population. People experiencing housing insecurity are also more likely to live with an alcohol and/or substance use condition<sup>3</sup>. It is estimated that 20–25% of people experiencing homelessness, compared with 6% of those that are housed, have severe mental illness<sup>4</sup>. Others estimate that up to one-third of those experiencing homelessness<sup>5</sup>.

**It is estimated that 20–25% of people experiencing homelessness have severe mental illness<sup>4</sup>**

Targeted populations can also include individuals who are unemployed or underemployed and/or considered to be indigent. This status often signifies a lack of health insurance coverage and/or access to medical care and overall wellness supports. According to combined 2008 to 2012 National Survey on Drug Use and Health data, adults aged 18 to 64 who were unemployed were more likely than those in other employment groups to have had a substance use condition in the past year<sup>6</sup>.



Individuals with co-occurring disorders can also find themselves in need of mobile support. Many individuals who develop substance use disorders (SUD) are also diagnosed with mental health conditions, and vice versa. Multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa <sup>7,8</sup>.

Targeted efforts should always be made to engage with high-risk individuals, such as Intravenous (IV) drug users and polysubstance users. Injecting substances such as cocaine or heroin greatly increases the likelihood of transmission of disease, which can create additional barriers when trying to find and sustain recovery from addiction.

According to DrugAbuse.gov, people who inject drugs (PWIDs) contract hepatitis C (HCV) by sharing contaminated needles and other drug injection paraphernalia. One recent national study found that 64.7 percent of injecting drug users (IDUs) who had been injecting for 1 year or less were already

infected with the hepatitis C. Overall prevalence of HCV was 76.5 percent among IDUs who had been injecting drugs for 6 years or less. According to the CDC, IDUs accounted for 9% (3,641)<sup>b</sup> of the 38,739 diagnoses of HIV in the US in 2017.

HIV infection associated with intravenous drug use (IDU) has decreased substantially in the last 20 years in Rhode Island. In the last five years, just over 3% of newly-diagnosed cases were attributed strictly to IDU. A significant factor in the success of reducing IDU transmission is AIDS Care Ocean State's ENCORE (Education, Needle Exchange, Counseling, Outreach and Referral) Program that has been operating in Rhode Island since 1995.

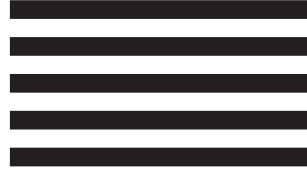
In addition to these priority populations, increasing access to transportation is a critical component in outreach to high-risk populations. Home-delivery services to rural locations as well as transportation to and from community resources can connect people to lifesaving resources.

# Cultural Considerations

Cultural considerations are essential to providing person-centered recovery support services. Cultural differences such as languages spoken, dialect, preferences, and opinions can hinder an individual's willingness or ability to access treatment and recovery support services.

Cultural considerations include a person's racial, ethnic, and religious identity as well as lifestyle and social network preferences. For example, providing services within a large homeless encampment requires its own set of unique practices, which may differ greatly from practices utilized in an office or other public setting.

Providing services to vastly different populations presents an opportunity to learn from those who you serve. Practicing compassion and empathy when asking questions will help you determine a client's comfort level, and in turn, will aid in navigating the nuances and etiquette of various cultures. It is imperative to respect the beliefs and wishes of the people you serve.



# CHAPTER THREE

## HOW TO OUTREACH

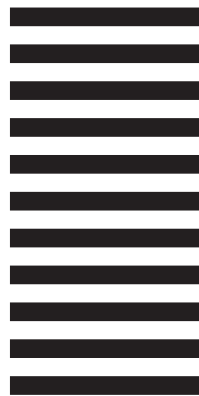
### Learning Objectives:

- Understand the benefits of peer support
- Learn the ways to help your clients
- Learn techniques for hard-to-reach clients

# HOW TO HELP



# ROLES AND RESPONSIBILITIES <sup>9</sup>



## **Motivator and Cheerleader**

Believe in capacity for change. Motivate, encourage, and celebrate.

## **Ally and Confidant**

Serve as a loyal, caring, trustworthy, stable, and consistent presence. Active listener.

## **Truth Teller**

Provides honest and helpful information. Offers suggestions. Helps to identify patterns of behavior. Offer feedback on recovery lifestyle. Ask motivational interviewing questions, such as, "How is that working for you?" Focus on recovery and wellness. Always discuss healthy choices.

## **Role Model**

Offer one's own life as an example of healthy living, leading by example. Provide stage-appropriate recovery and treatment information.

## **Problem Solver**

Identify potential problem areas. Assist client with problem solving. Do not tell the client the 'right' way, but rather assist with options while remaining non-judgmental.





# ROLES AND RESPONSIBILITIES <sup>9</sup>

## Resource Broker

Provide linkage to the recovery community, treatment, and other supports. Know the systems of care and how to navigate them. Have established contacts and recovery partnerships throughout the community.

## Advocate

Be an advocate for individuals and the populations you serve. Assist clients with protecting their rights. Act as a representative for the client when requested and appropriate.

## Community Organizer

Help establish a support network for the individual and serve as a connector.

## Friend and Companion

Reduce power differential by presenting as an equal or 'peer-to-peer' when possible.

Your role is **not** to be a sponsor, therapist, nurse, doctor, or priest/minister/rabbi.

# SERVICES PROVIDED

Direct service offerings may vary from agency to agency. If your specific agency does not provide the following services, consider having a direct stream-lined referral mechanism in place to an outside agency who does.

## Harm Reduction Supplies

(i.e., Needle Exchange)

## Naloxone (Narcan)

## Training and Distribution

## Clothing Vouchers

## Peer Support

You can help to indirectly provide services by connecting individuals to any agency that specializes in providing specific services. Whenever possible, offer a warm hand-off to ensure the client is connected to the referral.

- Stable housing
- Recovery housing
- Homeless shelter and programming
- Mutual Aid support groups
- HIV and HCV testing, care and treatment
- Food pantries and food subsidies (i.e., food stamps)
- Substance use treatment – inpatient, outpatient, long-term residential
- Medication Assisted Treatment - including Methadone, Suboxone, Subutex, Vivitrol, Antabuse
- Mental health counseling and psychiatric care
- Transportation assistance
- Additional medical supports – such as access to diabetes, high blood pressure, and other treatment options
- Unemployment filing assistance
- COVID-19 testing, vaccination and treatment
- Medical insurance – linking to Health-sourceRI
- Employment services - resume building and support in all aspects of finding and keeping a job
- Smoking cessation
- Child care
- Schooling, continuing education, and vocational opportunities
- State identification, including birth certificates and Social Security cards
- Financial assistance for utility bills rent and other basic needs
- Primary care provider
- Family support groups



# **EVIDENCE-BASED ENGAGEMENT TECHNIQUES**

## MOBILE OUTREACH

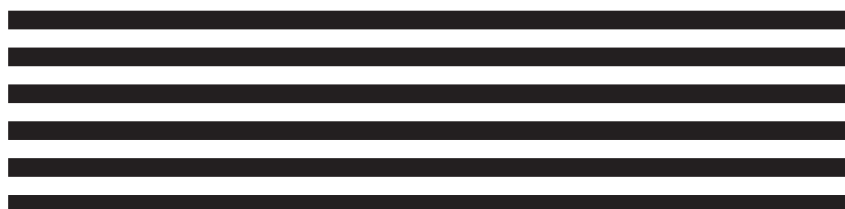
Mobile outreach workers provide reoccurring services to regular clients who are familiar with outreach teams independently. In other instances, outreach teams will typically approach individuals who are alert and receptive to assess their need and willingness to receive recovery support services. The goals of mobile outreaching are to increase engagement, both short and long-term. Understanding the important role that engagement plays, as well as evidence-based techniques to use, will best prepare any mobilized outreach provider for successful outcomes.

Evidence-based practices are crucial to ensuring successful outcomes. Many of the following techniques and research articles were compiled by Mark A Sanders, LCSW, CADC in his document entitled *“Strategies for Engaging Difficult-to-Reach, Multi-problem Clients with Substance Use Disorder”*.

**Engagement** can be defined as the progress a client makes during and throughout the treatment and wellness process. This can be measured by the relationship or rapport

that a client has with their service providers in addition to the achievement of their goals. Research studies show that client engagement is the number one evidence-based practice<sup>10</sup>. Research on addictions treatment reveals that the longer clients are engaged in treatment, the better the outcomes<sup>11</sup>. Other studies show that client engagement is the strongest predictor of short-term and long-term retention in addictions treatment<sup>12</sup>. Additional research found that the use of peers as recovery coaches is effective as a pre-treatment engagement strategy<sup>13</sup>. Recovery coaches can be used when offered in inpatient treatment settings by helping to keep clients engaged in treatment, thus decreasing the chance that they will leave treatment prematurely and as a post-treatment engagement strategy to help clients deal with the fragility of early recovery<sup>14</sup>.

Other findings on the importance and benefits of client engagement in addictions treatment include:



- Providers who possess qualities of empathy, nurturance, warmth, and genuineness do the best job of engaging chemically dependent clients in treatment <sup>15</sup>.
- An egalitarian relationship (one consisting of a belief that all people should be treated equal) during the treatment planning process helps clients stay engaged <sup>16</sup>.
- Respecting cultural differences during the engagement phase helps clients stay actively involved in therapy <sup>17</sup>.
- The use of motivational incentives (rewards) increases programmatic retention and recovery rates <sup>18</sup>.
- Engaging families or spouses in treatment increases programmatic compliance and retention, decreases relapses, and helps facilitate recovery <sup>12</sup>.
- Engagement strategies based upon the client's level of readiness to change helps reduce resistance and keep clients engaged in treatment longer <sup>19</sup>.
- Demonstrating a respectful alliance and honoring the client's right to self-determination by referring them to the level care they are motivated for increases programmatic outcomes <sup>20</sup>.
- Providing telephonic recovery support following discharge from treatment increases recovery rates <sup>21</sup>.

The aforementioned research is important, because historically, many chemically dependent clients are difficult to engage in services for myriad reasons, ranging from mandated status, a lack of motivation to discontinue drug use, discomfort with opening up to strangers, co-occurring conditions, multiple diagnoses, difficult symptomatology, initial therapeutic approaches that increase resistance, and confrontation techniques that leave clients feeling defensive. Thus, 50% of chemically dependent clients fail to make their second services appointment <sup>22</sup>.

## **Below is a list of strategies to engage difficult-to-reach, chemically dependent clients in services.**

### **□ Provide a welcoming atmosphere.**

When clients are met with a friendly greeting from a mobile provider or facility's intake staff and are invited into a comfortable setting, it can be easier to facilitate rapport. Every effort should be made to make the client feel comfortable.

### **□ Offer a snack while talking with the client.**

This hospitality can be instrumental in reducing client resistance within the first few minutes of contact. Low-cost incentives, such as chips, granola bars or a bottle of water, have been effective in increasing engagement and programmatic retention in addictions treatment. It is difficult to expect anyone to focus on wellness when they are experiencing hunger.

### **□ Exude warmth.**

This provider quality is effective in facilitating client engagement <sup>16</sup>. Research indicates that when clients hear a warm tone in a provider's voice prior to or during sessions, client dropout rates can decrease <sup>23</sup>.

### **□ Explore the client's experience with treatment and services in the past.**

If the experience was negative, let them know how the experience can be different this time.

### **□ Minimize confrontation.**

Confrontation leads to resistance and premature termination. There are studies that report a strong link between provider confrontation and clients returning to drug use. Other studies reveal that confrontation can be traumatizing to chemically dependent women, as the great majority of them have histories of trauma prior to treatment<sup>23</sup>.

### **□ Engage in mutual treatment planning.**

This respectful approach allows the individual to be a partner in their own recovery and treatment. This process can begin by asking the client, "What would you like to accomplish in treatment?" or "What would you like to see different in your life?"

## Focus on a strength and something the client does well as soon as possible during the rapport-building phase.

Many chemically dependent clients are defensive and resistant to services because they feel they have failed. A strength-based approach can decrease that defensiveness<sup>24</sup>. Provider approaches that focus too much on what clients have done wrong, rather than on what they are capable of doing right, leave clients feeling defensive and resistant to help<sup>25</sup>.

Clients are often asked questions in the initial intake session that increase their feelings of stigma and defensiveness, such as:

- How much do you drink?
- How many times have you relapsed?
- Have you ever been treated for mental illness?
- How many times were you hospitalized?
- Have you ever attempted suicide? How many times?
- Have you ever had a venereal disease?
- Have you ever shared a dirty needle?
- Have you ever been arrested? How many times? How many felonies?

Strength-based questions can be instrumental in decreasing clients' resistance and facilitating engagement<sup>24</sup>. Examples include:

- What do you do well?
- How have you been able to endure so much?
- What do you like to do in your leisure time?
- What are the best three moments you can recall in your life?
- What is the best thing you have ever made happen?
- What is your previous life suffering preparing you to do with the rest of your life?
- Which of your life challenges have taught you the most about your own resilience?
- What sources of strength did you draw from as you faced these challenges?
- What have you learned from what you've gone through?

## □ Utilize stage-based interventions.

Many chemically dependent clients are in various stages in terms of their readiness to change<sup>28</sup>. These stages of change, according to DiClemente, include:

- **Precontemplation stage.** At this stage the client is not considering the possibility of change. The client is unaware of having a problem or needing to make a change.
- **Contemplation stage.** The client is aware of the problem, and the client is ambivalent about making a change.
- **Determination stage.** The client is motivated to do something about the problem and has not yet taken the initiative.
- **Action stage.** The client engages in action for the purpose of bringing about change.
- **Maintenance stage.** The client engages in behavior to sustain the change. When chemically dependent clients are in the maintenance stage, they have been abstinent for six months or longer.

Research reveals that stage-based interventions are effective in facilitating rapport with clients<sup>19,20</sup>. Stage-based interventions can be particularly effective for clients with multiple problems because it allows the provider to base intervention strategies on the client's level of readiness to change each problem<sup>26</sup>.

## □ Have a sense of humor.

The shortest distance between two people is a good laugh. Humor in therapy has been found to reduce resistance<sup>27</sup>. Laughter can be the great equalizer<sup>27</sup>. Humor increases feelings of equality in the provider/client relationship; it brings the idealized provider back to life; it can reduce resistance; it decreases cross-cultural tension; and it facilitates bonding between provider and a chemically dependent individual. An important goal for using humor is to improve the relationship between the provider and client, lessen client tension, increase client comfort, and help the client gain insight.

## □ Be willing to have a sensitive discussion about race, gender, and other differences if they are barriers to communication.

This can facilitate the building of rapport. A good time to have such a discussion is when the provider senses that the differences they have with their client are barriers to trust<sup>17</sup>.



## □ **Avoid power struggles.**

Power struggles decrease engagement and can lead to premature termination<sup>20</sup>. One way to avoid power struggles is to roll with the individual's resistance. This can be accomplished by simply acknowledging the client's discomfort when certain subjects are brought up and allowing the discussion to shift to other areas<sup>23</sup>.

## □ **Avoid early labels.**

Early labels can lead to clients feeling defensive and being more difficult to engage<sup>20</sup>. When a service provider diagnoses a client prior to engagement and the client is resistant to the diagnosis, the client may become defensive and may not be receptive to treatment as a result<sup>23</sup>.

## □ **Ask for permission to give feedback.**

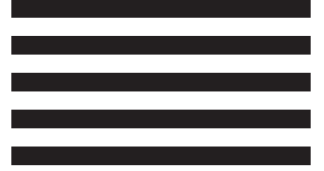
This respectful approach can go a long way toward facilitating rapport. For many years, addictions support staff have given individuals unsolicited feedback filled with opinions combined with confrontation, which often created therapeutic walls rather than therapeutic bridges<sup>19</sup>.

## □ **Be aware of countertransference reactions.**

The negative reactions providers may have toward clients can increase clients' resistance to receiving support. Many difficult-to-reach clients with substance use disorders have myriad behaviors that are easy to judge, as others are victimized by their behaviors. Providers who have negative reactions to the people they serve can use these situations to seek supervision, therapy, peer support, or academic pursuits in order to work with these individuals effectively.

## □ **Recognize many pathways of recovery.**

The addictions field has a history of assuming that there is only one way that people recover—namely, treatment followed by 12-step attendance. While this one-dimensional approach has helped many, it has produced a great deal of resistance in others. As the field of addictions treatment emerges, along with research, we are learning that clients have a variety of approaches to recovery, including solo recovery, virtual recovery, religious styles of recovery, medication-assisted recovery, harm reduction, 12-step recovery, and cultural pathways to recovery. Honoring the client's pathway to recovery can be instrumental in reducing resistance<sup>13</sup>.

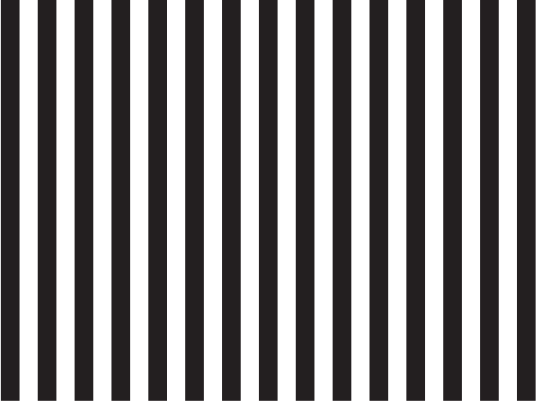


# CHAPTER FOUR

## WHERE TO OUTREACH

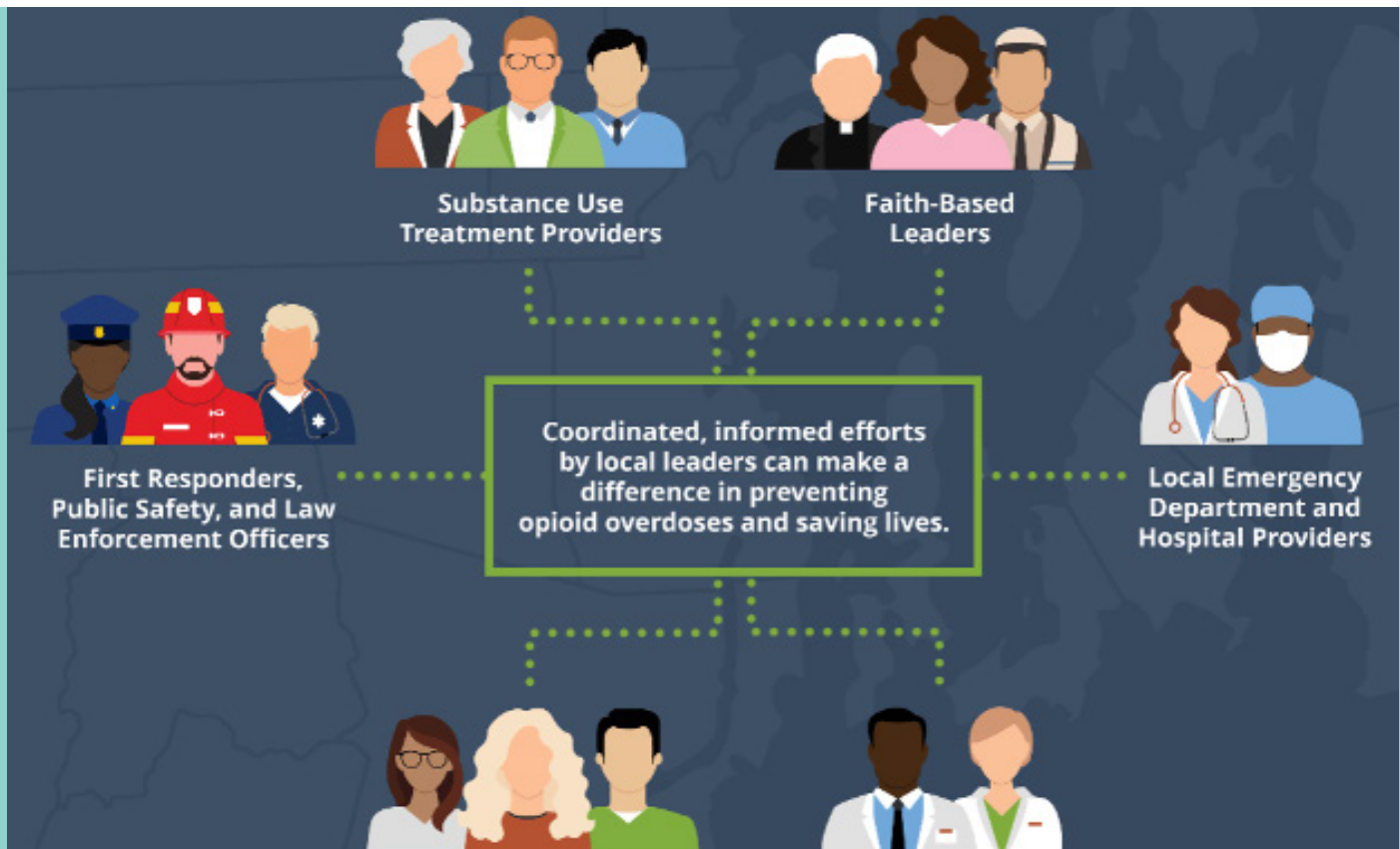
### Learning Objectives:

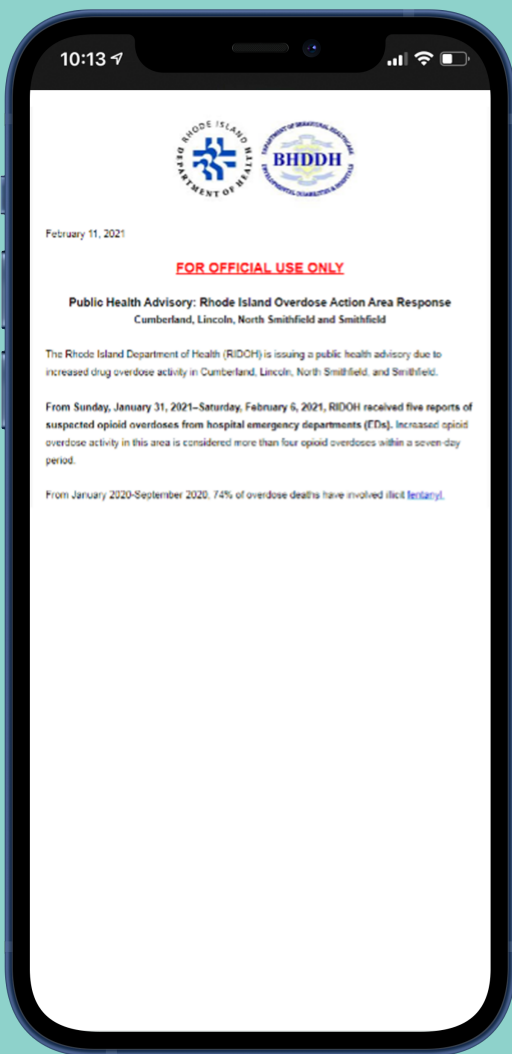
- Understand what resources are available to you
- Develop a strategy for your community
- Learn ways to engage with community partners



# STATE TARGETED RESPONSE

Mobile service providers are uniquely positioned to respond quickly and effectively to regions where data shows a trend of overdose spikes. These data sets are provided by RIDOH with assistance from the Health Equity Zones and Brown University.



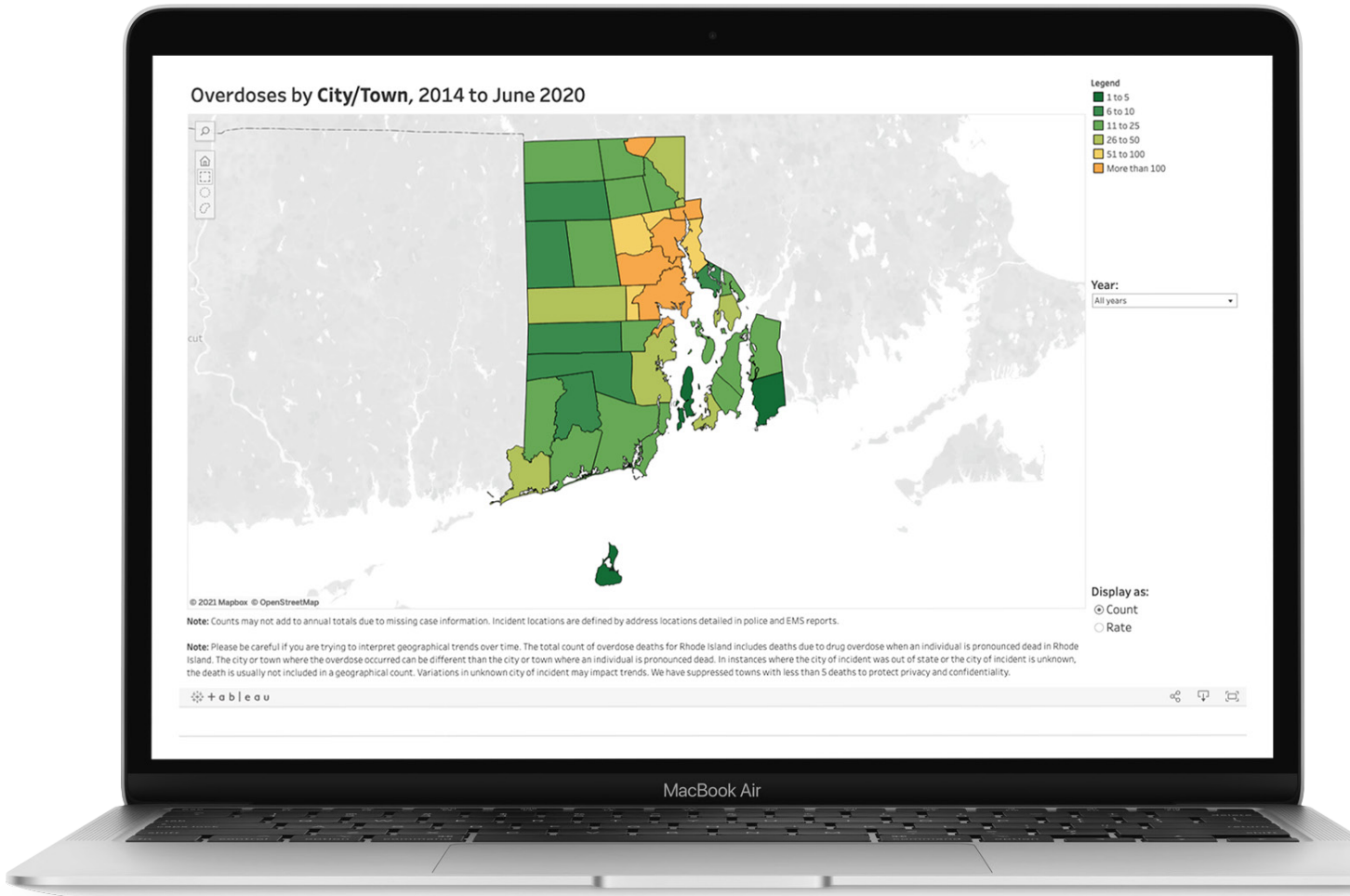


## ROAAR Alerts

RIDOH and BHDDH manage the Rhode Island Overdose Action Area Response (ROAAR) notification system to alert local stakeholders of sudden increases in opioid overdoses. These email alerts inform regional and community leaders to take action to prevent overdose and save lives.

# PREVENTOVERDOSERI.ORG

**PreventOverdoseRI.org** is Rhode Island’s overdose information website. The site contains updated fatal and non-fatal overdose data, as well as information on statewide naloxone distribution and medication assisted treatment services. The site provides safer drug use resources and information about treatment and recovery support services available throughout the state.



## OVERDOSE DENSITY MAPS

Overdose density maps (also called “heat maps”) show overdose activity throughout Rhode Island. These maps can be queried to reflect certain dates, times, geographical regions, and other factors using RIDOH’s non-fatal and fatal overdose surveillance systems. For example, heat maps can display overdoses occurring in public settings or during specific hours of the day to better inform street outreach and mobile efforts. These maps are provided on a regular basis by RIDOH.



# COMMUNITY INFORMED EFFORTS

**In addition to data response, there are opportunities to connect with more local organizations to best understand the needs in the communities you serve.**

The following are a few examples of how to stay informed:

## **Prevention Coalitions:**

Rhode Island has 38 Prevention Coalitions and seven Regional Prevention Coalitions. These coalitions meet frequently, and meetings can be attended by anyone who is interested in participating or collaborating.

## **Treatment Centers and Community-Based Organizations**

It is imperative for outreach workers to partner their work alongside agencies who provide both inpatient and outpatient services. This allows for streamlining cross-referrals to and from both agencies. It also presents opportunities to understand current availability and program capacity as well as recent trends surrounding client needs.

## **Street-Based or Word of Mouth**

As mobile services are provided to individuals, it is appropriate to inform those individuals that your services may be accessed by any adult. Handing out additional business cards or resources for clients to distribute within their social circles can lead to additional referrals and connections.



# CHAPTER FIVE

## HARM REDUCTION APPROACH

### Learning Objectives:

- Understand the importance of harm reduction
- Integrate a harm reduction approach into your work
- Learn about naloxone and needle-exchange resources

## PRINCIPLES

Harm reduction is an evidence-based, public health approach that uses practical strategies to reduce the harmful consequences associated with certain high-risk behaviors <sup>28</sup>.

Mobile efforts should consist of person-centered care; it is imperative to work towards increasing overall health and minimizing risk.

Services can often focus on clean needles and safe consumption kits, safe injection facilities, fentanyl test strips, condom distribution and naloxone distribution.



Fentanyl is a synthetic opioid so potent that a miniscule amount (equivalent to several grains of salt) can cause a fatal overdose. Yet it's difficult for people who use drugs to detect, which presents a major public health hazard given how commonly fentanyl is used to lace heroin or cocaine <sup>29</sup>.

(image provided by Brown University).

**Below are a few examples of harm reduction approaches:**

- If a person is an intravenous drug user (IDU) who shares syringes, they might be at a greater risk of transmitting infectious diseases. Connecting them to a needle exchange program, such as AIDS Care Ocean State, could be an effective way to help them access infectious disease testing to minimize risk of infectious disease transmission.
- If a person uses drugs alone, they are at greater risk for experiencing a fatal overdose. Discuss ways in which they can minimize this risk by increasing the likelihood for someone to intervene with naloxone and educate them on the use and benefits of fentanyl test strips.
- Educate on how-to and the benefits of using fentanyl test strips. Fentanyl test strips are easy-to-use tests to see if drugs have some types of fentanyl in them. Please note: Fentanyl test strips might not detect some fentanyl-like drugs that have been found in Rhode Island, like Carfentanil, Sufentanil, Alfentanil, Benzylfentanyl, Benzoylfentanyl, U47700, and U49900. Use care whether or not you get a positive test.
- If a person thinks they are purchasing prescription drugs not prescribed to them, and off the street, there is a strong likelihood that the drugs are counterfeit and could contain the deadly opioid, fentanyl. Discuss harm reduction strategies and opportunities to connect with a healthcare provider for treatment options.
- If a person has a substance use condition and a gambling problem, this can present additional barriers to finding and sustaining a better quality of life. If they refuse help for their conditions, focus on topics a client is willing to discuss.



## **HARMREDUCTION.org**

The National Harm Reduction Coalition (NHRC) believes that harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. The NHRC also considers the following principles central to harm reduction practice:

**Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them**

**Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others**

**Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies**

**Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm**

**Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them**

**Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use**

**Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm**

**Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use**

\*FOR MORE RESOURCES, VISIT **HARMREDUCTION.ORG**

## NALOXONE AND OVERDOSE PREVENTION

Naloxone is an opioid antagonist that is used to temporarily reverse the effects of an opioid overdose, namely slowed or stopped breathing. Expanding the awareness and availability of this medication is a key part of the public health response to the opioid epidemic. Naloxone is a safe antidote to a suspected overdose and, when given in time, can save a life. Research shows that when naloxone and overdose education are available to community members, overdose deaths decrease in those communities <sup>30</sup>.

Every mobile outreach worker should carry naloxone on them to administer if they encounter an overdose. Every CHW and CPRS should also be an ambassador for this medication by training individuals and the general public on how to appropriately respond to an overdose and administer Naloxone when needed. Naloxone can be acquired by any individual at any pharmacy throughout Rhode Island, or by visiting **preventoverdoseri.org** for free delivery. Connect with your agency or supervisor to determine the best method of securing larger quantities of naloxone for the intention of community distribution.

Naloxone can also be used as a harm reduction tool in addition to an engagement technique. There are many instances that occur where an individual is not yet willing to seek treatment for their drug use, but they would be willing to take a kit of naloxone. This presents a vital opportunity to begin building a relationship and rapport with the person and gently remind them of existing services when they are ready.

## NEEDLE EXCHANGE INFORMATION

The AIDS Care Ocean State's ENCORE program offers statewide needle exchange services at no cost to participants. It is the longest-running needle exchange program in the state. ENCORE's goal is to reduce the risk of HIV transmission among people who inject drugs (PWIDs). ENCORE offers risk-reduction counseling, HIV testing, prevention, education, and referrals to substance use treatment services and medical care facilities. The ENCORE program provides services in a variety of settings including fixed sites, street outreach, mobile van outreach, and home delivered services.

Partnering with this service is crucial in order to reduce harm for individuals and the greater community. To inquire about opportunities to directly offer harm reduction supplies to the individuals you serve, visit **www.aidscaresos.org**.



# CHAPTER SIX

## SAFETY AND POLICIES

### Learning Objectives:

- Learn how to do outreach safely
- Learn how to transport clients safely
- Understand your expected role

# OUTREACH SAFETY GUIDELINES

These safety guidelines for street outreach do not address how to handle difficulties once they arise. These guidelines address the needs of a street outreach worker who operates in a very different work environment than staff who are office-based.

- Outreach is conducted in two to four person teams. No team member should conduct outreach activities alone. Stay together. If one person needs to take a break, the whole team takes a break.
- Stay on well-lit streets in designated areas at all times.
- Always carry business cards and identification with you. Do not hesitate to identify yourself and your work. Do not give out personal information such as your address or phone number. Refer people to the office.
- Inform people of what you are doing and why.
- Identify yourself and what you are doing when asked by the police. Be polite to police officers and follow their direction. Be sure to get badge numbers and note the time of any interactions with the law enforcement and describe it in a report to your supervisor so they can be made aware.
- Do not stand and argue with someone who does not agree with what you are doing. Avoid confrontation or debate of any kind.
- DO NOT outreach while smoking. DO NOT give away cigarettes or lighters to clients while outreaching.
- Do not approach those who are giving “signs” that they do not want to be bothered. Trust your instincts about who to talk to or not.
- Do not approach people from behind.
- Do not be critical of your partner or co-workers in public while conducting outreach. Always present yourselves as a team.
- Wear comfortable clothes and shoes. Do not overdress.

- Do not carry valuables or other personal possessions such as jewelry, large amounts of money, radios, etc. Do not carry anything that you would not give up.
- Do not call attention to yourself by wearing unusual or distracting clothing.
- Friends or family members CAN NOT accompany you during outreach shifts.
- Do not hang out with any friends or family members while working.
- Do not interrupt the sale of sex or drugs for money. Leave the area immediately without drawing attention to yourself or others. Leave the area if tension or violence is observed or perceived.
- Avoid confrontations of any kind. Do not interfere with disputes or romantic interactions of any kind.
- Be aware of your surroundings. Do not walk in front of moving vehicles.
- Do not try to diagnose illnesses of any kind. Instead, recommend testing or professional evaluation.
- Maintain confidentiality with all clients you meet.
- Do not accept gifts, food or buy any merchandise from clients.
- Do not give or lend money to clients.
- Do not accept or hold any type of controlled substance.
- Never enter any client's homes (or camp site) without permission from the client.
- Inform supervisor of any unusual developments, questions or concerns.
- In case of an emergency, call or have another person call 9-1-1.
- Alert the on-call supervisor to the end of each and EVERY shift.

# TRANSPORTATION GUIDELINES



It is the responsibility of each employee to maintain a valid driver's license, as well as active insurance and registration on any personal vehicle during its use for work-related tasks. Failure to comply with this may result in re-assignment of job duties. Employers can provide federal standard mileage reimbursement to employees for distance traveled during work-time transportation (exempt from this is home to work commute). Employers requires that employees only transport individuals when adequate supervision/ staffing is possible, as defined by your direct supervisor. Employees may not transport more than the appropriate capacity of individuals for their vehicle at a time. All passengers and employees are required to wear seatbelts while traveling in employees' vehicles. Please consult your direct supervisor regarding transporting clients if any questions or non-mentioned scenarios arise.

## **INTOXICATED INDIVIDUAL:**

During Outreach/ Mobile Services, transporting an intoxicated individual is a common occurrence. It is at the unanimous decision of the entire "Mobile team" to determine whether the individual exceeds an "unsafe" threshold of intoxication. If the individual is presenting unsafe levels of any type of intoxication (i.e. not responsive, non-ambulatory etc.) call 9-1-1.

## **IF AN OVERDOSE OCCURS:**

It is always recommended for all outreach workers to carry naloxone AND call 911 in the event of an overdose. Outreach/Mobile Peer Workers are trained in opioid overdose prevention and intervention upon hire and may be expected to administer naloxone followed by appropriate overdose prevention response. In the event of overdose and rescue, any employees involved in the "incident" must report it immediately to their supervisor and complete an incident report the same day.

## **PARAPHERNALIA/SUBSTANCES ON PERSON**

If it is known that an individual receiving transportation services is "carrying" any substances and or drug paraphernalia, it is mandatory that the outreach team/ employee asks the individual to safely dispose of said substances and or drug paraphernalia. (Note; in the event of being pulled over and possibly "searched" during client transportation, you can be held legally accountable for any substances and/or drug paraphernalia.)

## **IF AN INDIVIDUAL IS PRESENTING SUICIDAL/ HOMICIDAL THOUGHTS/ACTIONS**

If an individual is presenting suicidal and or homicidal thoughts/ actions, it is mandated that staff contact 911 or emergency services for that individual to ensure safety for all parties involved. It is recommended for all staff to attend training regarding mental health intervention and referral.

## **INAPPROPRIATE BEHAVIOR:**

It is REQUIRED that all staff maintain healthy boundaries and implement their organization's policies on this matter when serving any population during outreach/ Mobile Service efforts. The organization explicitly forbids any staff member from developing an unprofessional and/or exploitative relationship with clients, in addition, any sexual contact with clients is STRICTLY forbidden and will result in IMMEDIATE termination.

If a client is displaying inappropriate behavior towards staff, it is at the employee's discretion to decide whether or not they feel comfortable in continuing direct services to the "client". If an employee does not feel comfortable serving a specific "client", that employee may consult with their supervisor(s) to discuss options regarding this matter (i.e. transferring "client" to another staff person).

## **NEEDLE EXCHANGE BACKPACK POLICY (ACOS/ENCORE)**

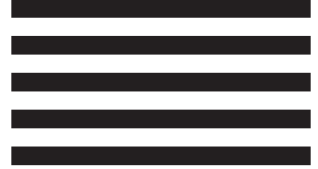
a. The outreach team shall inform individuals of the backpack-based exchange program as well as continue to refer clients to the fixed sites.

b. When a client encounters the exchange team, greet them warmly. Find out if they are interested in exchanging and ask if they have exchanged before.

c. If they have not exchanged before but are interested in the program, the outreach team will educate them about exchange services and ask them if they wish to be enrolled in the ENCORE program.

d. No client identifiers such as names and address shall be collected and written down or kept on records. Outreach team members must protect client's confidentiality and anonymity. Everyone on the shift is responsible for protecting the client's confidentiality and anonymity. Outreach team members that violate client confidentiality will be terminated. No information about clients will be passed on to other individuals or agencies. Outreach team members must not identify clients to the police. Any interactions with the police during the outreach or any request for information will be referred to the Prevention Supervisor or Program Director.

e. If clients are interested in enrolling and/or exchanging, the entire team and the client will move off of the main road, and will conduct the interaction on a side street. The space will be chosen at the discretion of the team leader.



# CHAPTER SEVEN

## PROGRAMMATIC SUPPORT

### Learning Objectives:

- Understand how to be supported in this work
- Learn the “do’s and do not’s” of this work
- Learn how to close existing gaps in the community



# STRUCTURE OF SUPERVISION

## FOR THE EMPLOYEE:

Employees can expect to receive the same standard of supervision as outlined in the Rhode Island BHDDH requirements for supervision of CPRS and CHW, in addition to specific agency guidelines. However, it is important to note that supervision of Mobile Outreach workers can be structured a bit differently when compared to an on-site worker. This may include daily check-ins and/or hourly check-ins depending on the circumstances of any given outreach shift.

Communication is key to receiving the safety and support you need to be of service in the community. It is strongly recommended to always carry a cellular device and establish an understanding with your direct supervisor as to the preferred method of contact (i.e. phone calls, text messages).

Working on a mobile team is quite different from traditional work settings in the sense that you always have a partner. It is your responsibility to provide a supportive working environment for your colleagues as well. During outreach shifts, it is important to operate as a cohesive unit and notify your supervisor immediately if something does not seem right with your partner.

# STRUCTURE OF SUPERVISION

## FOR THE SUPERVISOR:

In addition to state requirements and agency guidelines, increased levels of supervision are recommended for outreach workers. Understanding each employees' triggers, comfortability and skillsets will allow you to help your staff grow and develop in this career. Establishing strong communication methods and expectations will afford you the opportunity to best support your staff. Frequent discussions and evaluations around boundaries are of value to ensure staff are following guidelines. Below are recommendations for successful supervision:

- Periodically riding with the outreach worker to pick up or drop off clients
- Periodically going with the outreach worker during mobile outreach
- Doing formal case reviews with each outreach worker
- Doing audits to monitor outreach worker documentation
- Using a case presentation method in individual/team supervision
- Using role playing in supervision

Your role as supervisor also includes building a healthy team. Understanding the strengths and weaknesses of each staff member allows for strategic pairing. It also provides an opportunity for staff to teach and learn from one another. More in-depth support and information can be found in the **additional reference reading**.

Working in mobile settings can present additional ethical dilemmas when compared to traditional work settings. Fortunately, you are part of a larger team who can help navigate you through these considerations as they arise.

**Below are some examples for you to discuss with your team and supervisor:**

- Giving a client your home phone number
- Hugging a client
- Visiting a client at night
- Inviting a client to your home
- Wanting to keep a homeless client in your home overnight
- Lending personal money to a client
- Developing a personal friendship with a current client
- Developing a personal friendship with a former client
- Having a sexual relationship with a current or former client
- Helping a client clean her house
- Taking a client's dirty laundry home with you to wash
- Having an intimate relationship with a family member of a current or former client
- Accepting a gift from a client
- Giving a gift to a client
- Helping a client move from one apartment to another
- Hiring a client to do work for you
- Serving as an AA or NA sponsor for a client or family member of a client
- Socializing with a client away from work
- Wearing your work badge or identification openly when speaking with a client in public
- Leaving personal information about you or other clients visible in your car
- Taking personal phone calls while in the community

In addition to these situations, you must also consider the larger team and organization that you represent. There are advantages to working on a team. If you come across someone who may be a conflict for you to provide services to (such as a friend, family member or former romantic partner), it is best to notify your outreach partner immediately of this conflict. They can decide whether you are able to provide services or if you should call your supervisor for additional support. In terms of setting healthy boundaries with clients, a good indicative question to ask is “Would I do this for any of my clients?” This will help to determine your motives and reaffirm your own personal boundaries when operating in a “grey” area.

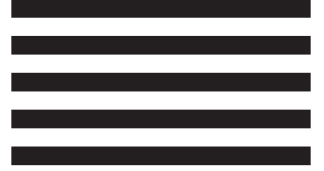
## **IDENTIFY BARRIERS**

Mobile outreach workers are best positioned to identify and address barriers in the communities they serve. Working directly with state departments and outside agencies to acknowledge these issues will further advance the progress of eliminating such barriers. Examples of such barriers can include:

- Current treatment capacities
- Gaps in care or resources
- Client treatment at facilities
- Recent trends in drug supply
- Lack of coordination amongst inter-agency efforts
- Evolving stigma or public perceptions amongst general public, law enforcement and first responders

Mobile outreach programs are also tasked with identifying programmatic barriers, such as:

- Sustainable program funding
- Cultural sensitivity barriers
- Accessibility barriers



# CHAPTER EIGHT

## SUCCESSFUL OUTCOMES

### Learning Objectives:

- Understand why data collection is important
- Learn the importance of human connection
- Fundamentally understand the different aspects of recovery

# DATA COLLECTION

Data collection is a necessary and important part of outreach work for many reasons, including:

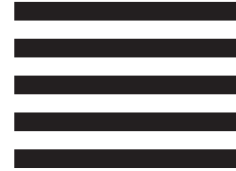
- Any mandated reporting to the state or other funders
- Pursuing grant-writing and future funding opportunities
- Documenting short and long-term progress
- Merging with other data sets to understand the bigger picture
- Guiding decision-making
- Identifying trends and responding accordingly

You may be asked to collect data for different purposes, depending on how your organization is funded. Some funders ask for data to be collected for programmatic monitoring and quality improvement purposes. Other funders conduct program evaluation and will ask you to collect data related to specific evaluation questions. You may also be asked to contribute to evaluation planning, depending on the evaluation approach. Programmatic monitoring will go throughout the lifetime of a project or program, while program evaluation typically has a specific start and end date.

## DATA COLLECTING METHODS

Data collection methods include surveys, interviews and focus groups that have become primary instruments for collecting information. Today, with help from web and analytics tools, organizations are also able to collect data from mobile devices, website traffic, server activity and other relevant sources, depending on the project.

It is important to learn how to integrate data collection throughout your work. This can be done in several ways and is a skill that can be developed. When you approach someone on the street while holding a clipboard and ask them 5 direct questions that you need answered, you may compromise your ability to connect deeply and honestly with a client. This can immediately create a power differential and/or invite resistance from the client. Alternatively, those same five questions could be creatively infused into a casual conversation and then formally documented after the service has been provided. Each Community Health Worker and/or Certified Peer Recovery Specialist provider can add their own unique nuances to their craft of data collection.



## **TYPES OF DATA**

There are two types of data: quantitative data and qualitative data. Quantitative data is any data that is in numerical form such as statistics and percentages. Qualitative data is more descriptive information, such as appearance, smell, and quality. Data collected by your organization is considered primary data collection.

Some organizations might also make use of 'secondary data' to help assist in their decision-making processes. Secondary data is can be either qualitative or quantitative in nature and has been previously collected by a separate entity for various and different purposes.

## **DATA ENTRY AND STORAGE**

Data is often collected anonymously and confidentially. It is required for all service providers to be made aware of HIPAA (Health Insurance Portability and Accountability Act) laws and respond accordingly by keeping certain records and information safely secured. This also protects the confidentiality of the people you serve. When working in mobile environments or in public settings, consider ways in which you can collect information discreetly, such as moving away from public walkways and finding a quiet setting that offers greater privacy. In addition, if you are going to assign any kind of ID to your clients, make sure that the ID cannot be connected to the client in any way, and that you are maintaining the privacy of their identity. Enter all data into required systems as soon as possible to maintain quality.

## **SHARING PERSONAL STORIES**

Never underestimate the power of personal stories. People who struggle with mental health conditions or alcohol and substance use disorders can greatly benefit from seeing success had in the lives of others who have overcome such struggles. When working as a CPRS or CHW, it is imperative to spotlight these successes. This can be done through sharing parts of your own story when appropriate or connecting individuals to peer-to-peer services. Personal stories can also lead to impactful anecdotal data, which can further drive efforts statewide.

As you see the lives of the people you serve be improved, it is an opportunity to share those successes as well. These individuals can also continue their journey of recovery by finding meaningful ways to contribute to society, including volunteering for agencies who work in the recovery field. Finding opportunities to volunteer and give back can often lead to gainful employment as well.

Having a team of outreach workers that includes individuals who were once served by an outreach team is an ideal way to perpetuate success and further lead to greater outcomes.

# Recovery

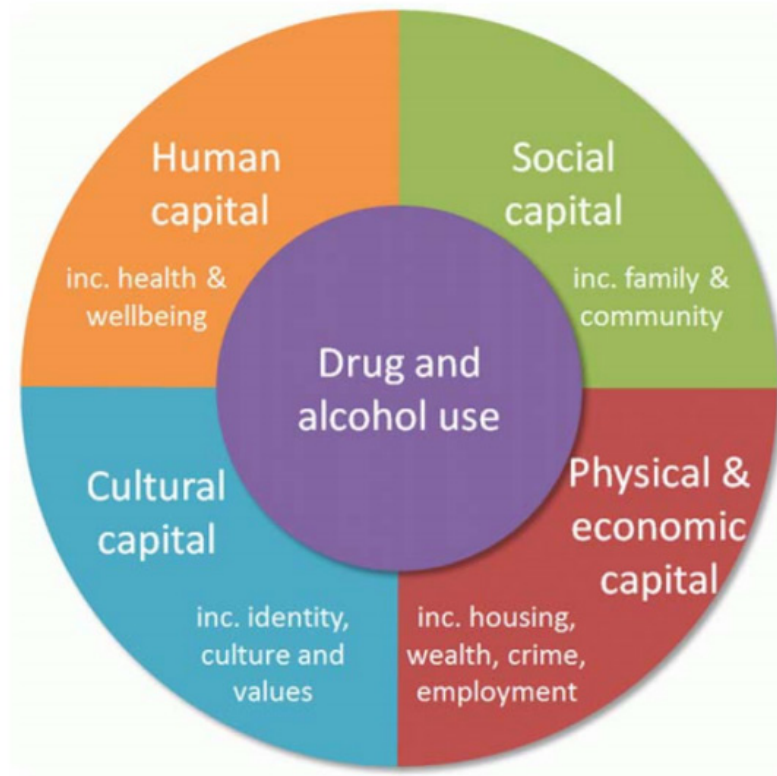
Recovery Capital is the total resources that a person has available to find and maintain their recovery. William White defines four types of recovery capital <sup>33</sup>:

## 1. Personal recovery capital.

This includes an individual’s physical and human capital. Physical capital is the available resources to fulfill a person’s basic needs, like their health, healthcare, financial resources, clothing, food, safe and habitable shelter, and transportation. Human capital relates to a person’s abilities, skills, and knowledge, like problem-solving, education and credentials, self-esteem, the ability to navigate challenging situations and achieve goals, interpersonal skills, and a sense of meaning and purpose in life.

## 2. Family/social recovery capital.

These resources relate to intimate relationships with friends and family, relationships with people in recovery, and supportive partners. It also includes the availability of recovery-related social events.



Source: ACMD (2013).



### 3. Community recovery capital.

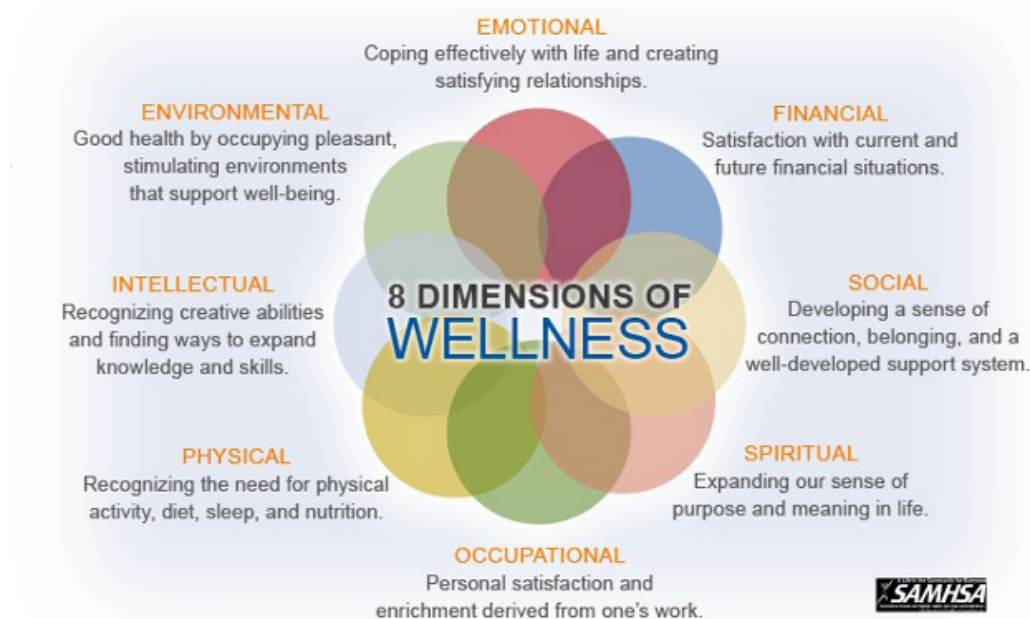
This includes attitudes, policies, and resources specifically related to helping individuals resolve substance use disorders and/or mental health challenges.. Community resources are vast.

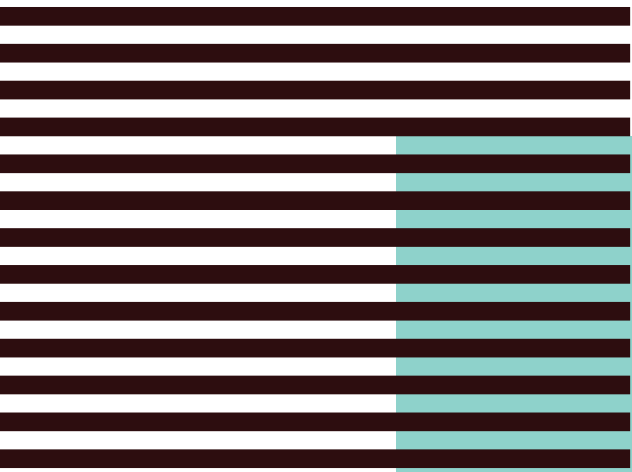
According to White, they can include:

1. Recovery activism and advocacy aimed at reducing stigma
2. A full range of addiction treatment resources
3. Peer-led support, such as mutual-aid meetings, that seek to meet the diverse needs of the community
4. Recovery Community Organizations
5. Recovery support institutions, educational-based recovery support such as recovery high schools and colleges, recovery housing, and recovery ministries and churches.
6. Visible and diverse local recovery role models
7. Resources to sustain recovery and early intervention programs, like employee assistance programs, and drug courts

### 4. Cultural capital.

These resources resonate with individuals' cultural and faith-based beliefs, including resources for Native Americans and other faith backgrounds, including and not limited to: Christianity, Islam, and Judaism.





# Conclusion

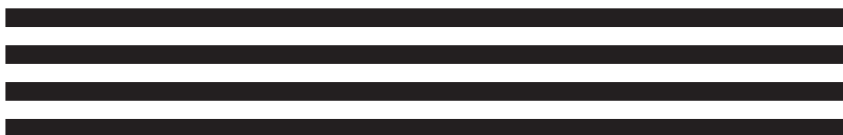
## Conclusion

There are 24 million Americans in recovery from addiction; thus, there are 24 million ways in which a person can recover. Although there are many similarities in terms of consequences, situations and experiences of those who struggle with addiction, each individual loses something different. It is therefore implied that every individual engaged in recovery is trying to 'recover' something different.

As a provider of recovery support services, it must be acknowledged that success varies from person to person. There is no solid metric or scale representing success. There is no finish line or certificate of completion. Recovery is not a linear event, but rather a process of ups and downs (and sometimes lefts to rights!). The success of recovery support services is measured in developing healthy rapport with individuals who are

struggling, building relationships founded on trust, mutual respect and openness yielding a willingness to partner together and improve the overall quality of one's life.

Embedded within the context of all services provided should be a vision and firm belief of hope. Hope that the individual you are working with can recover. Hope that they too can proceed to live a life of meaning and value, while bringing greater purpose to the community they are a part of. It is these very individuals who can someday help the next struggling person to find recovery.



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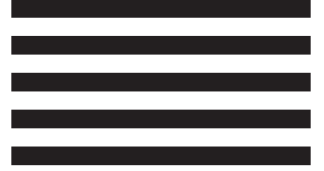
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#### **ADDITIONAL REFERENCE READING:**

1. THE DELIVERY AND SUPERVISION OF OUTREACH SERVICES2003ProjectSAFEOutreachManual.pdf (williamwhitepapers.com)
2. ENCORE NEEDLE EXCHANGE PROGRAM: <https://www.aidscares.org/Our-Services/Prevention-Center/Needle-Exchange>
3. SAMPLE OUTREACH DATA COLLECTION SHEET (Parent Support Network, 2020) [See attached page]"



## APPENDIX

# COVID-19 BEST PRACTICES

- Learn how to mitigate the risk of COVID-19 transmission
- Recommended guidance for mobile teams



# CDC GUIDANCE <sup>31</sup>

As we navigate the COVID-19 pandemic, stay up-to-date on current guidance from the Centers for Disease Control and Prevention (CDC) online at <https://www.cdc.gov/covid19>

Some best practices: Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.

It's especially important to wash your hands:

- Before eating or preparing food
- Before touching your face
- After using the restroom
- After leaving a public place
- After blowing your nose, coughing, or sneezing
- After handling your mask
- After changing a diaper
- After caring for someone sick
  
- Clean and disinfect frequently touched surfaces multiple times throughout the day. This includes tables, doorknobs, light switches, counter tops, handles, desks, phones, keyboards, pens, clipboards, and vehicles.
  
- Monitor your health on a daily basis.
  
- Be alert for symptoms. Watch for fever, cough, shortness of breath, or other symptoms of COVID-19.
  
- This is especially important if you are running essential errands, going into the office or workplace, and in settings where it may be difficult to keep a physical distance of six feet.
  
- Take your temperature if symptoms develop. Don't take your temperature within 30 minutes of exercising or after taking medications that could lower your temperature, like acetaminophen.
  
- Cover coughs and sneezes.

- Always cover your mouth and nose with a tissue when you cough or sneeze, or use the inside of your elbow. Do not spit.
- Throw used tissues in the trash.
- Immediately wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.

# MOBILE OUTREACH RECOMMENDATIONS

The role of a mobile service provider during COVID-19 is two-fold. It is imperative that you keep yourself safe by following up-to-date CDC guidance, however it is equally important to educate the individuals you serve on how they can remain as safe as possible. Work directly with clients to discuss their risk factors and help to minimize potentially harmful circumstances wherever possible.

Coordinate community resources to ensure you can provide basic Personal Protection Equipment to homeless and indigent individuals that you provide services to. This includes masks, gloves, and hand sanitizer.

Encourage clients to get tested regularly for COVID-19. Keep updated with new testing sites, hours and sign-up logistics so that you can point people to their nearest options in real-time.

Should a client test positive for COVID-19, learn the resources in your community that will allow them to quarantine on-site for the appropriate duration of time. This is especially important for homeless populations. If the person you are serving is required to quarantine, be an advocate for them in securing what they may need (food, medications, etc.,)

You may need to adjust your outreach shift hours on a weekly basis to mitigate the risk of contracting COVID-19.

Utilize telephone recovery support methods in place of face-to-face sessions whenever possible.

If your mobile offerings are limited and someone needs transportation to a treatment facility, consider working within your agency to offer taxi or ride-sharing services to those individuals. This will provide the service needed to the client while keeping you safe as well.

Consider working in stable and/or consistent teams prior if you are not yet vaccinated.

Get tested regularly! If you are feeling sick, notify your supervisor immediately.

Date \_\_\_\_\_ In Response To Hotspot Alert \_\_\_\_\_

**ID (1st 2 letters of first name + # of letters in last name + DOB (mm/dd/yy))** \_\_\_\_\_

**OD In The Last 30 Days?** Y/N

**Was 911 Called?** Y/N

**If NO, Why? (ADD NOTE)**

**Homeless?** Y/N

**# Supplies Distributed**

**Narcan** \_\_\_\_\_ **Needles** \_\_\_\_\_ **Strips** \_\_\_\_\_

**Basic needs** \_\_\_\_\_ **Food** \_\_\_\_\_

**Condoms** \_\_\_\_\_ **Smoking tips** \_\_\_\_\_

**Snorting Kits** \_\_\_\_\_ **Injection Kits** \_\_\_\_\_

**Services (add note)** I.P. \_\_\_\_\_ O.P. \_\_\_\_\_ Peer \_\_\_\_\_ Other \_\_\_\_\_

**Referrals:** HIV test \_\_\_\_\_ HCV test \_\_\_\_\_ Needle X \_\_\_\_\_  
**Housing** \_\_\_\_\_ **Basic Needs (food/water)** \_\_\_\_\_

**ETHNICITY:** Hispanic Non-Hispanic

**RACE:** Black White Asian Other \_\_\_\_\_

**GENDER:** M F N/B

**TRANS:** YES NO Unknown

**AGE: 18-24 25-34 35-44 45-54 55-64 65+** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Notes:**

**ID (1st 2 letters of first name + # of letters in last name + DOB (mm/dd/yy))** \_\_\_\_\_

**OD In The Last 30 Days?** Y/N

**Was 911 Called?** Y/N

**If NO, Why? (ADD NOTE)**

**Homeless?** Y/N

**# Supplies Distributed**

**Narcan** \_\_\_\_\_ **Needles** \_\_\_\_\_ **Strips** \_\_\_\_\_

**Basic needs** \_\_\_\_\_ **Food** \_\_\_\_\_

**Condoms** \_\_\_\_\_ **Smoking tips** \_\_\_\_\_

**Snorting Kits** \_\_\_\_\_ **Injection Kits** \_\_\_\_\_

**Services (add note)** I.P. \_\_\_\_\_ O.P. \_\_\_\_\_ Peer \_\_\_\_\_ Other \_\_\_\_\_

**Referrals:** HIV test \_\_\_\_\_ HCV test \_\_\_\_\_ Needle X \_\_\_\_\_  
**Housing** \_\_\_\_\_ **Basic Needs (food/water)** \_\_\_\_\_

**ETHNICITY:** Hispanic Non-Hispanic

**RACE:** Black White Asian Other \_\_\_\_\_

**GENDER:** M F N/B

**TRANS:** YES NO Unknown

**AGE: 18-24 25-34 35-44 45-54 55-64 65+** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Notes:**

**ID (1st 2 letters of first name + # of letters in last name + DOB (mm/dd/yy))** \_\_\_\_\_

**OD In The Last 30 Days?** Y/N

**Was 911 Called?** Y/N

**If NO, Why? (ADD NOTE)**

**Homeless?** Y/N

**# Supplies Distributed**

**Narcan** \_\_\_\_\_ **Needles** \_\_\_\_\_ **Strips** \_\_\_\_\_

**Basic needs** \_\_\_\_\_ **Food** \_\_\_\_\_

**Condoms** \_\_\_\_\_ **Smoking tips** \_\_\_\_\_

**Snorting Kits** \_\_\_\_\_ **Injection Kits** \_\_\_\_\_

**Services (add note)** I.P. \_\_\_\_\_ O.P. \_\_\_\_\_ Peer \_\_\_\_\_ Other \_\_\_\_\_

**Referrals:** HIV test \_\_\_\_\_ HCV test \_\_\_\_\_ Needle X \_\_\_\_\_  
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**Notes:**