Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Toolkit

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TOOLKIT ROADMAP:
A PRACTICAL GUIDE TO STRENGTHENING AFBSS ON THE GROUND

PURPOSE AND CONTEXT

The Assertive Field-Based Initiation for Substance Use Disorder Treatment Services Toolkit was developed to support counties, providers, and community partners in implementing Assertive Field-Based Substance Use Disorder Treatment Services (hereafter referred to as Assertive Field-Based SUD Services, or "AFBSS"), a required component of California's Behavioral Health Services Act (BHSA). The toolkit serves as a practical implementation resource intended to help organizations operationalize field-based substance use disorder (SUD) services while adapting implementation strategies to local needs, resources, and service environments.

AFBSS is a core BHSA strategy for expanding access to treatment among individuals who face significant barriers to care. Rather than relying solely on traditional facility-based treatment models, AFBSS emphasizes proactive engagement in community settings, rapid treatment initiation, including medications for addiction treatment (MAT), and ongoing support through a "no-wrong door" approach to care. The model is designed to better reach individuals experiencing homelessness, justice involvement, co-occurring conditions, and other factors associated with poor access to treatment and elevated overdose risk.

VISION FOR FIELD-BASED CARE

AFBSS represents a shift from facility-centered care to a community-centered model that brings services directly to individuals where they live, spend time, and seek support. The model is grounded in voluntary, person-centered engagement and emphasizes rapid access to treatment, coordinated service delivery, and sustained recovery support. AFBSS is intended to function as a bridge to ongoing treatment and recovery-oriented services rather than as a replacement for existing outpatient, residential, or inpatient treatment programs.

Central principles of the model include assertive outreach, rapid treatment initiation, integrated care, equity-driven service design, and strong coordination across behavioral health, medical, housing, justice, and public health systems, including well-managed transitions of care.

TIPS FOR USING THIS TOOLKIT

This toolkit is designed to be used, not sit on a shelf. While the sections are organized around key components of AFBSS implementation, it should not be read from beginning to end or completed in a specific order. Instead, think of it as a reference guide and resource library that can be used as challenges arise, questions emerge, or implementation priorities evolve.

PRACTICAL IMPLEMENTATION FOCUS

This toolkit is built on the understanding that successful implementation requires more than policy direction or conceptual guidance. It provides practical, culturally responsive, trauma-informed, and field-ready resources designed for real-world environments characterized by competing priorities, limited resources, workforce challenges, and high-acuity populations. Across all sections, the toolkit prioritizes clarity, brevity, and action-oriented guidance to support use in fast-paced community settings.

The content was developed based on common questions, challenges, and implementation gaps identified by counties, providers, and community partners working in the field. **Not every section, tool, or resource will be relevant to every organization or stage of implementation.** Readers are encouraged to focus on the content that best aligns with their role, priorities, and local needs.

Throughout the toolkit, you will find practical resources designed to support implementation:

Resource Type	How It Supports Implementation
Reflection questions	Support planning, discussion, and shared decision-making.
Practice tips and field notes	Translate concepts into practical actions for real-world field settings.
Checklists and worksheets	Guide planning, implementation, assessment, and continuous improvement efforts.
Templates and planning tools	Provide adaptable materials that can be customized for local use.

The toolkit is intentionally designed to be practical, flexible, and action-oriented. Whether you are designing a new initiative, strengthening existing services, training staff, facilitating stakeholder discussions, or addressing a specific implementation challenge, **use the tools and resources that are most relevant to your work**.

INTENDED AUDIENCE

The toolkit is designed primarily for California county behavioral health departments and the providers and partners involved in planning, implementing, overseeing, and strengthening AFBSS. It was developed for a broad, multidisciplinary audience that includes:

- County behavioral health department and behavioral health system leaders.
- Program administrators and supervisors.
- Clinicians and prescribers.
- Substance use counselors.
- Peer support specialists.
- Outreach and engagement staff.
- Care coordinators and case managers.
- Administrative personnel.
- Community-based organizations.
- Cross-sector partners in healthcare, housing, public health, and justice systems.

Because successful implementation requires coordinated action across multiple systems, the toolkit supports users across different roles and levels of responsibility while promoting alignment around a shared model of care and common implementation principles. The toolkit is also designed to support organizations at different stages of implementation. Readers may engage with the sections most relevant to their responsibilities, priorities, and implementation needs while maintaining alignment with a shared model of care and consistent expectations.

TOOLKIT SECTION OVERVIEW

The toolkit is organized around the core components required for successful AFBSS implementation, as outlined below.

SECTION 1: AFBSS MODEL OVERVIEW AND CORE COMPONENTS

This section establishes a shared understanding of AFBSS, including its purpose, required components, target populations, and alignment with Behavioral Health Services Act (BHSA) requirements. It outlines the core principles of the model—including assertive outreach, rapid treatment initiation, integrated care, equity, and “no-wrong door” access—and provides guidance on the required program elements needed to implement AFBSS at the local level.

SECTION 2: UNDERSTANDING INDIVIDUALS SERVED THROUGH AFBSS

This section helps teams better understand the priority populations to be served through AFBSS, including the role of substance use, co-occurring behavioral health and medical conditions, social determinants of health, trauma, and environmental factors in shaping service needs. It introduces practical approaches for screening and assessment that can help teams tailor service intensity, care coordination, and treatment approaches to individual needs.

SECTION 3: DATA-INFORMED COMMUNITY-BASED OUTREACH

This section provides practical guidance on using quantitative and qualitative data to identify priority populations, target high-risk locations, and inform community-based outreach strategies. It highlights approaches for integrating overdose surveillance, cross-system data, community knowledge, and lived experience to improve outreach effectiveness, strengthen engagement, and ensure resources are directed to individuals and communities at greatest risk.

SECTION 4: STAFFING, WORKFORCE CAPACITY, AND TRAINING

This section focuses on building and sustaining the workforce necessary to deliver effective field-based care. Topics include multidisciplinary staffing models, peer workforce integration, caseload planning, supervision structures, workforce development strategies, training frameworks, staff well-being, and implementation approaches designed to support high-quality, team-based service delivery in community settings.

SECTION 5: PARTNERSHIPS, COLLABORATION, AND COMMUNITY INTEGRATION

This section examines the critical role of partnerships in supporting AFBSS implementation and long-term success. It provides guidance on developing and sustaining collaborative relationships across behavioral health, healthcare, housing, justice, public health, and community-based systems, while emphasizing network-based approaches that improve service coordination, continuity of care, and access to comprehensive supports.

SECTION 6: CLINICAL PRACTICE AND SERVICE DELIVERY IN AFBSS

This section provides guidance for translating harm reduction principles into clinical practice, low-barrier engagement, integrated care, team-based service delivery, and quality improvement. Topics include harm reduction, shared decision-making, low-barrier service delivery, whole-person care, team-based care, communication strategies, care coordination, and approaches for measuring program effectiveness and outcomes.

SECTION 7: FIELD-BASED MEDICATION TREATMENT FOR SUBSTANCE USE DISORDERS

This section provides evidence-informed guidance on medications used to treat substance use disorders in community and field-based settings. Topics include medication management, procurement and storage considerations, medications for alcohol, nicotine, opioid, and stimulant use disorders, withdrawal management, medication initiation strategies, and approaches to improving access to medications for addiction treatment.

SECTION 8: FINANCING AND SUSTAINABILITY

This section provides a high-level overview of key considerations for financing, sustaining, and scaling AFBSS programs over time. It is intentionally concise and directs county behavioral health departments to the more detailed training, technical assistance, and fiscal guidance available through organizations contracted by DHCS to support BHSA financing and implementation.

ADVANCING EQUITY AND ACCESS

The toolkit also underscores equity as a foundational principle of AFBSS. Counties and providers are encouraged to use data, community expertise, and lived experience to identify populations at greatest risk, reduce disparities in access to treatment, and design culturally and linguistically responsive services. Equity considerations are integrated throughout implementation planning, staffing, outreach, service delivery, and performance monitoring.

CONCLUSION

Ultimately, this toolkit is intended to help communities strengthen their capacity to deliver high-quality, coordinated, and responsive field-based SUD services. By offering practical tools, implementation guidance, and evidence-informed strategies across critical operational and clinical domains, it supports counties and providers in expanding access to care, improving engagement and retention, strengthening workforce capacity, and advancing more equitable outcomes for individuals who have historically faced significant barriers to treatment and recovery services.

This toolkit is not intended to be exhaustive or prescriptive. Instead, it focuses on a curated set of high-impact domains that are critical to successful AFBSS implementation. Counties and providers are encouraged to build upon existing strengths, adapt strategies to local circumstances, and use the toolkit as a guide for phased implementation and continuous

improvement. By equipping counties and frontline staff with practical frameworks, models, tools, and implementation resources, the toolkit aims to strengthen engagement and improve outcomes across the continuum of recovery services, particularly for individuals and communities that have historically experienced barriers to care and have been disproportionately underserved.

SECTION 1:

ASSERTIVE FIELD-BASED INITIATION OF SUD TREATMENT SERVICES MODEL OVERVIEW AND CORE COMPONENTS

PURPOSE

Assertive Field-Based Substance Use Disorder Services (AFBSS) represent a required approach and set of programs under the Behavioral Health Services Act (BHSA) to expand access to lifesaving substance use disorder (SUD) treatment for individuals who face the greatest barriers to care. It responds to the reality that traditional facility-based SUD treatment models reach only a small proportion of people living with SUD and that more proactive, field-based strategies are necessary to prevent overdose and improve treatment access.

This section establishes a shared understanding of AFBSS including its purpose, required components, and policy expectations, as counties and providers engage with the implementation tools and resources presented later in this toolkit.

HOW TO USE THIS SECTION

This section provides an **overview of the AFBSS model, including its purpose, required components, target populations, and guiding principles**. As you review the content, consider:

- ☑ Which existing programs, partnerships, and services in my county already align with AFBSS principles and required components?
- ☑ What gaps, barriers, or implementation priorities should we focus on to meet AFBSS expectations, including data-informed outreach, mobile field-based services, open-access treatment pathways, and rapid MAT access?
- ☑ How can AFBSS advance my county's goals related to overdose prevention, equitable access to care, treatment engagement, and long-term recovery support?

Throughout this section, you'll find model overviews, implementation considerations, and planning resources. These tools can help you **understand BHSA expectations, assess alignment with existing services, and identify implementation priorities**.

DEFINITION OF AFBSS: A PROACTIVE, NO-WRONG DOOR MODEL

AFBSS includes proactive, field-based services designed to engage individuals living with SUD who are not currently connected to care and to support rapid initiation of SUD treatment. This includes Food and Drug Administration (FDA)-approved medications for addiction treatment (MAT) in low-barrier community settings.

FIELD TIP

Assertive, field-based engagement prioritizes meeting people where they are, not where the system expects them to be.

Many organizations find that engagement improves when services are delivered in places that are familiar, accessible, and comfortable for the individual.

What AFBSS is:

- ✓ A proactive, voluntary, engagement and "no-wrong door" treatment initiation model.
- ✓ A mechanism to reach individuals at high risk of overdose who remain unengaged in care, providing assertive outreach, treatment initiation support, and direct linkage to services rather than relying on traditional intake pathways that often create barriers to engagement.
- ✓ A required element of the Behavioral Health Care Continuum under BHSA.
- ✓ A bridge to ongoing SUD treatment and recovery-oriented services.

What AFBSS is Not:

- × A replacement for outpatient, intensive outpatient, residential, or inpatient SUD treatment.
- × A crisis-only or post-overdose response model.
- × A coercive or mandatory intervention.
- × Dependent on the creation of new Full Service Partnership (FSP) levels of care.

CORE VALUES AND GUIDING PRINCIPLES

All AFBSS programs are expected to reflect the following BHSA-aligned principles:

1. **Assertive, Field-Based Engagement**: Programs take responsibility for reaching people where they are, rather than relying on self-referral, appointments, or other traditional access points.
2. **No-Wrong Door Access**: Engagement in any AFBSS setting should facilitate immediate support, treatment initiation when appropriate, or direct linkage to the correct level of care.

REFLECT ON IT

Which AFBSS principles are already strengths within your organization?

Which principles present the greatest opportunity for growth or improvement?

Which of these principles would have the greatest impact if strengthened over the next 12 months?

3. **Voluntary, Person-Centered Care**: Participation in services and treatment decisions, including medication choice, remains voluntary and tailored to the individual's clinical needs.
4. **Rapid Initiation of Treatment**: Programs emphasize timely, and increasingly same-day, access to MAT and other clinically appropriate SUD services.

- **Integrated and Coordinated Systems**: AFBSS operates in coordination with behavioral health, medical, housing, justice, and public health systems and ensure well-managed care transitions.
- **Equity-Driven Design**: Programs intentionally address disparities in access, experience, and outcomes among populations historically underserved by SUD treatment systems.

PRIORITY POPULATIONS

AFBSS programs must prioritize BHSA-eligible individuals living with SUD treatment needs who are at high risk of overdose and poor outcomes, including individuals who are:

- Eligible for housing interventions services, including at-risk of homelessness, experiencing homelessness, or chronically homeless with a focus on those in encampments.
- Children and youth who are:
    - In, or at risk of being in, the juvenile justice system;
    - Reentering the community from a youth correctional facility;
    - In the child welfare system; or
    - At risk of institutionalization.
- Adults or older adults who are:
    - In, or at risk of being in, the justice system;
    - Reentering the community from prison or jail;
    - At risk of conservatorship; or
    - At risk of institutionalization.

Counties are expected to further identify and refine priority populations using local data, community planning processes, and cross-system collaboration.

REQUIRED AFBSS PROGRAM COMPONENTS

Under BHSA, counties are required to **provide rapid access to all FDA approved MAT** by operating at least one initiative in each of the following three core areas that comprise their assertive field-based programs:



Data-informed Targeted Outreach

Counties must conduct ongoing, targeted outreach to actively engage BHSA-eligible individuals with SUD needs. Outreach efforts must be informed by data and focused on populations and locations with elevated overdose risk.



Mobile Field-Based Programs

Mobile field-based teams must provide on-the-ground engagement, trust-building, harm reduction support, and direct provision of, or rapid referral and linkage to, SUD treatment and MAT in community settings.



Open-Access Clinics

The term, “Open-Access Clinics,” represents settings and/or approaches that provide low-barrier, low-threshold outpatient access to MAT and other SUD services, including same-day or walk-in care when feasible.

Counties may meet these requirements by building upon existing programs, strengthening current initiatives, or developing new models and partnerships, as appropriate to local context and readiness.

USE THIS TOOL

Ready to discuss priorities and next steps? Use the AFBSS Component Mapping Worksheet. > **Tool 1.A**

PROMISING AND ALIGNED PRACTICES

While not required, the Department of Health Care Services (DHCS) encourages AFBSS programs to incorporate the following practices to strengthen engagement, improve outcomes, and prevent overdose:

- **Harm Reduction Services**: Distribution of naloxone, harm reduction kits, and drug-checking supplies.
- **Primary Care Touchpoints**: Wound care, HIV and hepatitis C testing, and linkage to medical care.
- **Post-Overdose Follow-Up:** Targeted outreach to individuals following overdose events to provide education, support, and rapid access to MAT.
- **Peer Support Specialists:** Engagement and navigation support delivered by individuals with lived experience of substance use and recovery.

FIELD TIP

AFBSS implementation does not always require building something new.

Many counties may meet AFBSS requirements by strengthening existing or building new partnerships, expanding outreach capacity, improving treatment access pathways, and enhancing coordination across current programs rather than creating entirely new services.

Counties may collaborate regionally to share mobile teams or open-access clinics to maximize reach and efficiency.

RAPID ACCESS TO MEDICATIONS FOR ADDICTION TREATMENT (MAT)

Counties are required to ensure rapid access to all FDA–approved MAT, including methadone, buprenorphine, naltrexone, acamprosate, and disulfiram.

Key expectations include:

- **Rapid Access to MAT:** Outreach, mobile teams, and open-access clinics must work toward same-day MAT access over time.
- **Person-Centered Medication Choice:** Medication choice must be individualized based on clinical need, not program availability.
- **Coordinated MAT Referral Networks:** Programs not authorized to dispense certain medications (e.g., methadone) must establish effective referral and follow-up pathways to appropriate providers, including Narcotic Treatment Programs (NTPs) and medication units.
- **Long-Term Treatment and Recovery Support:** Counties must plan for MAT continuation and maintenance, including access to recovery-oriented services and behavioral therapies.

Counties that cannot assure same-day MAT access by July 1, 2026, are required to outline a phased plan in their BHSA Integrated Plans to meet this expectation by July 1, 2029.

DATA-DRIVEN TARGETING AND OUTREACH STRATEGY

AFBSS outreach is expected to be strategic and data-informed, not solely opportunistic. Counties are encouraged to collaborate with Emergency Medical Services (EMS), emergency departments, public health authorities, managed care plans, and community partners to identify:

- High-overdose geographic areas.
- Populations experiencing frequent overdose reversals.
- Trends on drug-related arrests or emergency service utilization.

Best practices include implementing coordinated overdose surveillance and referral systems that enable rapid post-overdose engagement, including outreach within days of a known overdose event or emergency department visit. Use of non-traditional data sources (e.g., syringe-exchange program utilization, drug coalition and other real-time review team data, etc.) should be encouraged.

EQUITY AND ACCESS AS CROSS-CUTTING EXPECTATIONS

Equity is a foundational expectation across all BHSA-funded services. AFBSS programs must be designed to:

- **Identify, Monitor and Address Inequities:** Use data to identify, monitor and address inequities related to racial, ethnic, age, gender, and other demographic factors.
- **Improve Equity in Access and Outcomes:** Reduce disparities in SUD treatment access, utilization and outcomes.
- **Deliver Responsive Services:** Provide culturally and linguistically responsive services.
- **Strengthen Community Partnerships:** Partner with community-based organizations serving historically marginalized populations.

REFLECT ON IT

How are equity considerations currently reflected in program design, staffing decisions, outreach strategies, and performance monitoring?

If your team could make one change over the next year to strengthen equity in access, engagement, or outcomes, what would have the greatest impact?

Equity considerations are incorporated into all of the statewide behavioral health goals and should inform AFBSS program design, staffing, outreach locations, and performance monitoring.

IMPLEMENTATION READINESS AND INTEGRATED PLAN ALIGNMENT

DHCS recognizes that counties vary in readiness and existing infrastructure for AFBSS implementation. Counties are provided flexibility to gradually meet requirements over a three-year implementation period from July 1, 2026, to July 1, 2029.

All counties are required to describe their AFBSS approach, timelines, and strategies for achieving required elements, including rapid MAT access, in their BHSA Integrated Plans.

This toolkit operationalizes the AFBSS model through practical tools, templates, and workflows that support counties and providers in meeting these requirements with fidelity and effectiveness.

USE THIS TOOL

Ready to discuss priorities and next steps? Use the AFBSS Implementation Priorities Worksheet. > **Tool 1.B**

SECTION 1 KEY TAKEAWAYS & RESOURCE MAP

- **AFBSS as a Strategy for Engagement:** AFBSS is required under BHSA and is designed to engage individuals with SUD who are not currently connected to care.
- **Core Values and Principles:** AFBSS emphasizes proactive outreach, no-wrong-door access, person-centered care, rapid treatment initiation, and equity-driven service delivery.
- **Priority Populations:** Counties should prioritize populations at highest risk of overdose, disengagement, and poor outcomes using local data and community input.
- **Required Program Components:** Every AFBSS approach must include data-informed outreach, mobile field-based services, and open-access treatment pathways.
- **Rapid Access to MAT:** Timely access to MAT, including movement toward same-day access when feasible, is a central expectation of AFBSS.
- **Data-Informed Outreach:** Outreach efforts should be strategic, targeted, and informed by data, community knowledge, and cross-system collaboration.
- **Equity as a Cross-Cutting Expectation:** Equity should inform program design, staffing, outreach strategies, partnerships, and performance monitoring.
- **Flexible Implementation Approaches:** Counties may build upon existing programs, partnerships, and services to meet AFBSS requirements.

IF YOU ARE READY TO...	GO TO...

Identify existing programs, partnerships, and resources that support AFBSS.	>	**Tool 1.A**	**AFBSS Component Mapping Worksheet**
Identify and prioritize implementation needs, gaps, and next steps.	>	**Tool 1.B**	**AFBSS Implementation Priorities Worksheet**

REFERENCES

California Department of Health Care Services. (2026). *Behavioral Health Services Act County Policy Manual*. https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE

SECTION 2:
UNDERSTANDING INDIVIDUALS SERVED THROUGH AFBSS

PURPOSE

This section provides a framework for understanding the individuals served through AFBSS and the factors that influence engagement, treatment, safety, and recovery. It explores how substance use, co-occurring behavioral health and medical conditions, trauma, social determinants of health, and environmental factors shape service needs and affect engagement in care.

It introduces practical approaches to screening, assessment, and acuity determination along with emphasizing person-centered approaches that support self-determination, reduce barriers, and promote meaningful engagement.

By understanding both the challenges and strengths of the population served, AFBSS teams can make informed decisions about outreach, care coordination, and service delivery. The goal is to support responsive, effective field-based care aligned with the needs and goals of the individuals and communities being served.

HOW TO USE THIS SECTION

This section explores the **characteristics, strengths, needs, and circumstances** commonly experienced by priority populations. As you review the content, consider:

- ☑ How do substance use, co-occurring conditions, trauma, and social factors influence the needs of individuals served through AFBSS?
- ☑ How can screening, assessment, and ongoing reassessment help teams identify strengths, risks, needs, and opportunities for support?
- ☑ How can AFBSS teams use information about acuity, complexity, and individual goals to tailor outreach, engagement, and service delivery?

Throughout this section, you'll find reflection questions, implementation considerations, practical tools, and assessment resources. These resources can help you **evaluate current practices, and identify tools to help improve screening and assessment**.

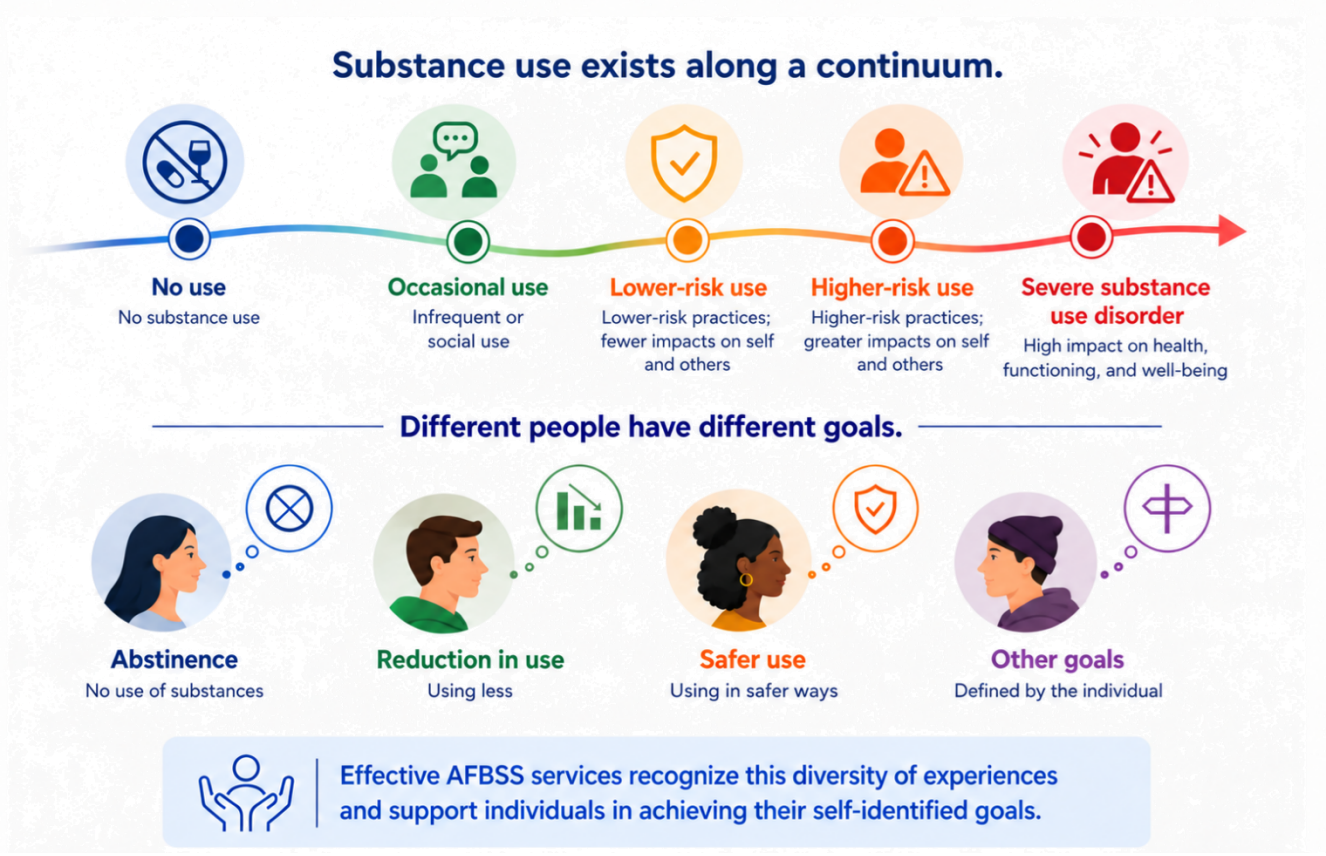
SUBSTANCE USE DISORDER AS A CHRONIC HEALTH CONDITION

Substance use disorder (SUD) is a chronic, treatable health condition that affects people across all communities, backgrounds, and life circumstances. Like other chronic conditions, recovery is often non-linear and may involve periods of improvement, recurrence, and re-engagement with care over time.

Not everyone who uses substances develops a substance use disorder. Substance use exists along a continuum, ranging from no use, to occasional use, low or high risk use, to severe substance use disorder. People may seek services for different reasons and at different points in their recovery journey. Some may be interested in abstinence, while others may prioritize reducing use, improving health, increasing stability, or reducing the risk of overdose and other harms.

REFLECT ON IT

- How are staff trained and supported to respond to return to substance use as an opportunity for re-engagement rather than a treatment failure?
- Do your measures of success reflect the goals of the individuals you serve, or only program-defined outcomes?
- What systems, policies, or practices help ensure services are flexible enough to support individuals with different goals related to substance use?



Effective AFBSS services recognize this diversity of experiences, avoid one-size-fits-all approaches, and support individuals in achieving their self-identified goals. Programs that have put into practice their understanding of SUD as a chronic health condition can better tailor services, build trust, and promote sustained engagement over time.

STRUCTURING AFBSS TO REFLECT THE REALITIES OF THE POPULATION SERVED

Individuals who benefit from AFBSS often experience multiple, overlapping challenges that affect health, safety, and access to care. These challenges may include:

- Homelessness or housing instability
- Co-occurring mental health conditions
- Chronic medical conditions
- Justice-system involvement
- Financial instability
- Limited access to transportation
- Trauma and adverse life experiences
- Social isolation and lack of support networks

For many individuals, substance use serves a purpose. Substance use may help individuals temporarily cope with trauma, emotional distress, untreated mental health symptoms, physical discomfort, social anxiety, or the realities of living in unsafe and unstable environments.

Because of these factors, traditional facility-based models often fail to engage individuals with the greatest need. Requirements such as scheduled appointments, transportation, abstinence expectations, or navigating multiple service systems can create barriers that prevent people from accessing care.

AFBSS is designed to reduce these barriers by bringing services directly to individuals in the settings where they live and spend time.

While AFBSS teams frequently work with individuals experiencing significant clinical, behavioral health, and social challenges, teams should also identify strengths, resources, and protective factors. Family connections, peer and recovery supports, cultural and community connections, employment, housing stability, prior treatment successes, and personal goals can all support engagement and recovery. Understanding both challenges and strengths helps teams develop more effective, person-centered care plans.

Because many individuals served through AFBSS have experienced barriers to care, stigma, trauma, housing instability, or fragmented service systems, engagement often requires more than providing information about services. Effective outreach is relationship-based, person-centered, and grounded in trust. Teams should recognize that immediate priorities may include food, shelter, transportation, safety, healthcare, or benefits, and that supporting progress on self-identified goals can create opportunities for ongoing engagement and future treatment conversations. Consistent, respectful outreach helps build trust and strengthen relationships over time.

USE THIS TOOL

Ready to explore approaches to outreach and engagement ? See Identifying and Supporting Behavioral Health Needs in Encampments.

SCREENING

Screening is designed to identify individuals who are at risk for and need further evaluation to diagnose specific conditions. Best practice is for universal screening of all patients, in all clinical settings, using standardized, validated questionnaires that have been tested in populations similar to those with which you will be working. For AFBSS, screening should occur to identify individuals who need assessment for risky substance use and co-occurring mental health symptoms.

Screening should be followed by a more comprehensive assessment when results identify concerns. A positive screening result does not establish a diagnosis. Rather, it signals the need for further evaluation, intervention and discussion, and, when appropriate, referral and care planning.

Screening results can help teams:

- Identify unmet health, behavioral health, and social service needs.
- Prioritize assessment and follow-up activities.
- Inform individualized care planning.
- Support integrated treatment approaches.
- Guide decisions regarding outreach, engagement, and care coordination.

Because health status, substance use, housing stability, and engagement frequently change over time, screening and assessment should be viewed as ongoing processes rather than one-

time events. Reassessment may be particularly important, especially following hospitalization, overdose, incarceration, housing transitions, significant life events, crisis episodes, or periods of disengagement from care.

UNIVERSAL SCREENING

Best practice is for SUD and mental health conditions to be addressed together by the same team, rather than in parallel silos. Universal screening can also help reduce bias by ensuring that all individuals are screened consistently rather than relying on assumptions about who may be at risk. Comprehensive care begins with understanding the individual's needs across multiple domains.

USE THIS TOOL

Ready to explore screening tools ? See Substance Use Disorder (SUD) Screening Tool Reference Guide.

> Tool 2.A

AFBSS teams should routinely screen for:

SUBSTANCE USE

- Substance use patterns
- Overdose risk
- Withdrawal symptoms
- Treatment readiness

MENTAL HEALTH

- Suicidality
- Depression
- Anxiety
- Trauma exposure
- Serious mental illness

PHYSICAL HEALTH

- Chronic medical conditions
- Infectious diseases
- Pregnancy-related needs
- Acute medical concerns

SOCIAL NEEDS

- Housing instability
- Food insecurity
- Transportation barriers
- Benefits and insurance needs

ASSESSMENT

Assessment is a more in-depth process used to better understand an individual's potential risks and concerns, determine their severity and impact, establish diagnoses when appropriate, and inform treatment planning.

In contrast to screening, assessment involves gathering additional information about an individual's symptoms, substance use patterns, strengths, goals, health conditions, social circumstances, and barriers to engagement. Assessment findings help teams determine what services may be needed and how those services should be delivered. Assessment should also explore an individual's priorities, recovery goals, readiness for change, preferences regarding services, and definitions of success.

Assessment should be individualized, person-centered, and integrated across substance use, mental health, physical health, and social service domains whenever possible. Because needs and circumstances change over time, assessment should be viewed as an ongoing process rather than a one-time event.

Structured assessment tools may be used to support comprehensive assessment, level of care determination, treatment planning, and ongoing care decisions for individuals with SUDs. For example, the ASAM Criteria Assessment is a standardized, multidimensional assessment tool that supports consistent evaluation across the six ASAM dimensions and helps inform individualized, patient-centered treatment recommendations and level of care decisions.

Tool	Purpose	Administration
ASAM Criteria Assessment Interview Guide	Standardized multidimensional assessment used to evaluate patient needs across the six ASAM dimensions, support level of care determination, and inform individualized treatment planning for SUD treatment.	Clinician-administered structured interview that guides assessment, risk rating, level of care recommendations, and treatment planning.

UNDERSTANDING ACUITY, RISK, AND COMPLEXITY

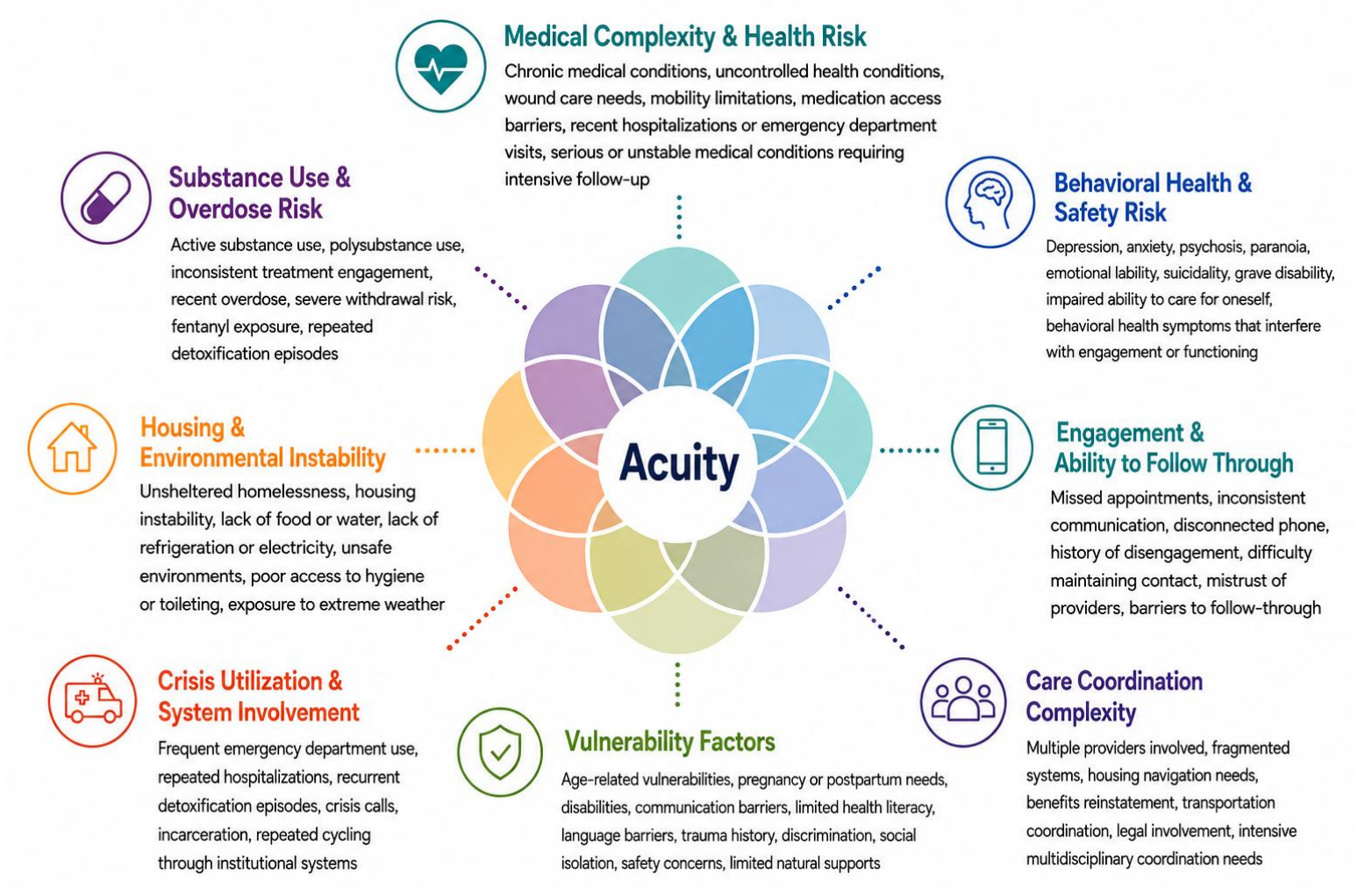
Acuity extends beyond diagnosis or symptom severity. It reflects the complexity, severity, instability, and immediate risk associated with an individual's medical, behavioral health,

USE THIS TOOL

Need to assess acuity levels? Use the AFBSS Acuity Considerations Tool. > **Tool 2.B**

substance use, environmental, engagement, and system-level needs. Understanding these factors helps teams determine appropriate outreach intensity, staffing (i.e., based not only on caseload but also client intensity), care coordination, and service delivery approaches.

FACTORS THAT INFLUENCE ACUITY



Using Acuity to Guide AFBSS Service Delivery

Acuity should also help teams determine how services are delivered.

Higher-acuity individuals generally require:

- More frequent outreach and field-based contact
- Smaller staff-to-client ratios
- Greater involvement from prescribers, nurses, peers, and care coordinators
- Team composition and multidisciplinary involvement
- Increased care coordination across healthcare, housing, and social service systems
- More frequent team review and reassessment
- Enhanced safety planning and crisis response capacity
- Reassessment timing and service transitions
- More persistent trust-building efforts, including culturally responsive, linguistically appropriate, and trauma-informed engagement strategies

FIELD TIP

Field-based work includes significant "invisible work."

Relationship building, outreach, transportation support, care coordination, follow-up, and navigating multiple systems often require substantial staff time. Caseload expectations are most effective when they reflect the realities of community-based work rather than traditional clinic productivity models.

Lower-acuity individuals may benefit from a less intensive approach focused on maintaining engagement, supporting recovery goals, and preventing escalation of needs.

Because acuity changes over time, teams should reassess individuals regularly and adjust service intensity as needs increase or stabilize.

For more information service delivery within the AFBSS model, see Section 6: Clinical Practice and Service Delivery in AFBSS.

SECTION 2 KEY TAKEAWAYS & RESOURCE MAP

- **Substance use exists along a continuum**, and individuals may have different goals related to their substance use, recovery, health, and well-being.
- **People served through AFBSS often experience overlapping challenges, including** behavioral health, medical, social, and environmental, but also bring strengths, resilience, and resources that can support recovery.
- **Trust is the foundation of engagement**. Effective outreach is relationship-based, person-centered, and grounded in self-identified goals.

- **Screening and assessment are ongoing processes** that help teams identify needs, strengths, risks, and opportunities for support.
- **Acuity goes beyond diagnosis**. Service needs are influenced by a combination of clinical, social, environmental, and engagement-related factors.

IF YOU ARE READY TO...	GO TO...	
Explore approaches to outreach and engagement	> Resource	Identifying and Supporting Behavioral Health Needs in Encampments
Explore screening tools for substance use, mental health, and social needs	> Tool 2.A	Substance Use Disorder (SUD) Screening Tool Reference Guide
Assess acuity levels	> Tool 2.B	AFBSS Acuity Considerations Tool

REFERENCES

Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017, May 30). *Standardized screening for health-related social needs in clinical settings: The Accountable Health Communities Screening Tool*. National Academy of Medicine. https://nam.edu/standardized-screening-for-health-related-social-needs-in-clinical-settings-the-accountable-health-communities-screening-tool/

Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., Bradley, K. A., & the Ambulatory Care Quality Improvement Project (ACQUIP). (1998). The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. *Archives of Internal Medicine, 158*(16), 1789–1795. https://doi.org/10.1001/archinte.158.16.1789

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11*(4), 330–341. https://doi.org/10.1177/1073191104269954

Haber, P. S. (2025). Identification and treatment of alcohol use disorder. *The New England Journal of Medicine, 392*(3), 258–266. https://doi.org/10.1056/NEJMra2306511

Higgins-Biddle, J. C., & Babor, T. F. (2018). A review of the Alcohol Use Disorders Identification Test (AUDIT), AUDIT-C, and USAUDIT for screening in the United States: Past issues and future directions. *The American Journal of Drug and Alcohol Abuse, 44*(6), 578–586. https://doi.org/10.1080/00952990.2018.1456545

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association, & Institute for Alternative Futures. (2016). *Accelerating strategies to address the social determinants of health: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*. https://prapare.org/

Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., Kaloupek, D. G., Schnurr, P. P., Kaiser, A. P., Leyva, Y. E., & Tiet, Q. Q. (2016). The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine, 31*(10), 1206–1211. https://doi.org/10.1007/s11606-016-3703-5

Sheehan DV, Lecrubier Y, Sheehan KH, et al. The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *J Clin Psychiatry*. 1998;59(suppl 20):22-33.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Substance Abuse and Mental Health Services Administration. (2026). *SAMHSA Overdose Prevention and Response Toolkit* (Publication No. PEP23-03-00-001). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/overdose-prevention-response-kit-pep23-03-00-001.pdf

Substance Abuse and Mental Health Services Administration. (2021). *Using motivational interviewing in substance use disorder treatment* (Advisory). U.S. Department of Health and Human Services. https://library.samhsa.gov/product/advisory-using-motivational-interviewing-substance-use-disorder-treatment-based-tip-35

Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction, 84*(11), 1353–1357. https://doi.org/10.1111/j.1360-0443.1989.tb00737.x

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5)*. National Center for PTSD. https://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: The Hooked On Nicotine Checklist. *Journal of Adolescent Health, 35*(3), 225–230. https://doi.org/10.1016/j.jadohealth.2003.10.004

SECTION 3:
DATA-INFORMED COMMUNITY-BASED OUTREACH

PURPOSE

This section provides an overview of how data can be used to inform Assertive Field-Based Substance Use Disorder Services (AFBSS). It begins by identifying how data can bolster outreach efforts, describing data sources and how to access them, and then explains how data can improve community engagement. There is a particular focus on **involving outreach teams in data interpretation and decision making** as well as utilization of qualitative information from community members and the people who are served.

The Behavioral Health Services Act (BHSA) requires county behavioral health departments to implement initiatives in three major pillars in the service of ensuring access to medications for addiction treatment (MAT): data-driven, targeted outreach for hard-to-reach populations; mobile field-based programs; and open-access clinics.

HOW TO USE THIS SECTION

This section provides **guidance on using data, community knowledge, and lived experience to inform outreach strategies and target populations at greatest risk**. As you review the content, consider:

- ☑ What data sources, community knowledge, and lived experience can help us identify who is at greatest risk and where outreach is most needed?
- ☑ Which priority populations may be underrepresented in available data?
- ☑ How can we use multiple data sources and field observations together to identify emerging risks and outreach opportunities?
- ☑ How can data help us determine where, when, and how outreach should occur to maximize engagement and impact?

Throughout this section, you'll find outreach planning tools, data considerations, and promising practices. These tools can help you **strengthen outreach strategies, prioritize resources, and improve engagement efforts**.

THE VALUES OF DATA-DRIVEN OUTREACH

By combining timely data, community knowledge, and lived experience, teams can identify priority populations, target outreach efforts, and continuously refine service delivery based on what is working.

Data can help outreach teams:

- **IDENTIFY** who is at highest risk.
- **DETERMINE** where and when outreach is needed.
- **TAILOR** outreach strategies and resources.
- **MONITOR** engagement and barriers.
- **EVALUATE** what is working and adjust.

Effective data-driven outreach happens when:

- **Data is interpreted through local knowledge.** Data points us in a direction, but local knowledge gives it meaning. Outreach staff, peers, and community partners help explain what the numbers reflect on the ground such as movement patterns, seasonal changes, or emerging risks that aren't visible in datasets.
- **Social dynamics guide how outreach is delivered.** Social dynamics—trust, relationships, informal networks, and safety concerns—shape whether people engage outreach teams or not. Data may identify a hotspot, but social dynamics determine timing, staffing, messaging, and whether a peer led approach is needed.
- **Counties support coordination without over-control.** Counties play a key role in data sharing, funding, and coordination, but over-prescriptive approaches can slow response and reduce responsiveness to changing conditions. Data-driven outreach works best when counties enable collaboration and alignment while allowing outreach teams to adapt based on real-time conditions.
- **Law enforcement data is used without compromising trust.** Deidentified or aggregate law enforcement data may help identify overdose patterns, emerging substance trends, and locations where outreach may be needed. Programs should establish clear boundaries between public health outreach and enforcement, use only information that is necessary and legally permissible, and avoid sharing personally identifiable information for outreach purposes. Outreach should remain separate from enforcement activities, as actual or perceived connections to surveillance or enforcement can undermine trust and engagement.

Data Sharing and Client Confidentiality

Data and information sharing should be used to support outreach, identification, engagement, care coordination, and service optimization for individuals at elevated risk. However, any access, use, release, or sharing of information related to substance use disorder treatment or services must comply with applicable federal and state confidentiality requirements, including HIPAA, FERPA, and 42 CFR Part 2.

Programs should ensure that information is used only for authorized purposes, limited to the minimum necessary, and disclosed only with valid client consent or another legally permissible basis for information sharing.

- **Data quality is continually assessed and supplemented with lived experience.** Regularly assess data for gaps, delays, and potential biases, and supplement quantitative information with lived experience, peer feedback, and frontline observations to support sense-making and more informed and equitable outreach decisions.

KEY CONCEPTS FOR OUTREACH PLANNING

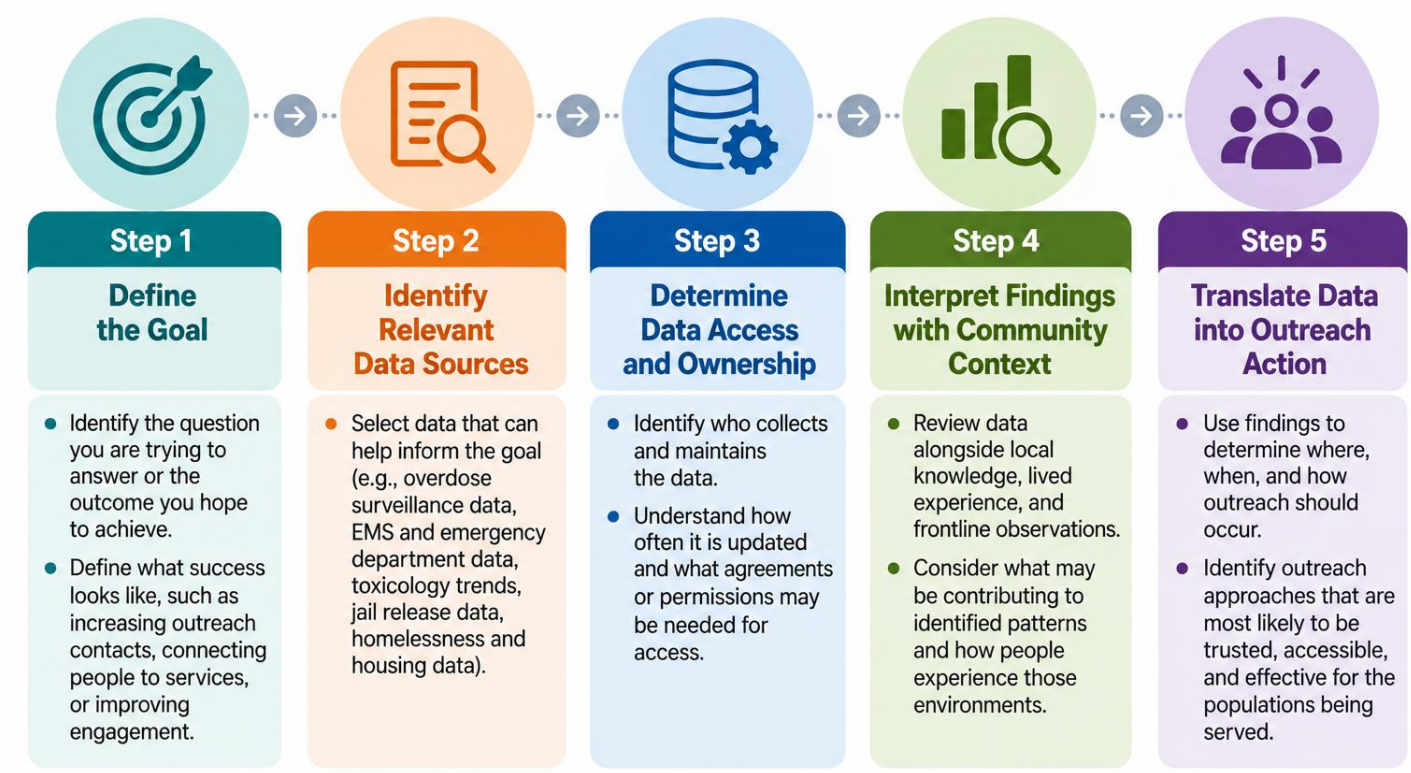
The concepts below play a central role in data-informed outreach planning and decision-making. Understanding how these concepts relate to outreach can help teams use data more effectively to identify priorities and adapt strategies to changing community needs.

Term	What It Means	Why It Matters
Outreach	Proactive efforts to identify and engage individuals at risk of overdose by bringing services and resources into community settings rather than waiting for them to seek care.	Data-informed outreach helps teams determine who may benefit from engagement, where outreach should occur, and how services can be delivered most effectively.
Community-Based Outreach	Outreach activities directed toward groups, networks, or communities at elevated risk of overdose.	Using data to direct community-based outreach can help target hotspots and priority populations.
Individual-Based Outreach	Direct, person-to-person engagement with an individual at risk of overdose to build trust, assess needs, and connect them to services.	Using data to direct individual-based outreach can help identify individuals experiencing elevated risk, such as those recently involved in an overdose event or transitioning from institutional settings.
Priority Populations	Groups experiencing elevated overdose risk, poorer outcomes, or barriers to accessing services, as identified through data, community input, and lived experience.	Helps teams focus limited outreach resources on populations most likely to benefit from proactive engagement and support.
Hot Spot	A geographic area experiencing a concentration of overdose events or overdose-related risk indicators during a defined period of time.	Helps teams determine where outreach resources should be deployed and where additional monitoring or community engagement may be needed.

PROCESS FLOW FOR IDENTIFYING AND USING DATA FOR OUTREACH

Data-informed outreach is most effective when it moves beyond simply collecting information and focuses on supporting real-world decisions. The process below provides a framework for identifying who may be at greatest risk, understanding community conditions, and determining where, when, and how outreach should occur. While counties may use different data sources and approaches, effective outreach generally follows the same progression: defining the goal, gathering relevant information, interpreting findings with community context, and translating insights into action.

The remainder of this chapter expands on each of these steps and describes how to combine quantitative data, lived experience, and community insight to support outreach decisions.



ROLES

Within this process, there are various roles that will need to be involved in each step. Consider who from your team and partners will fulfill each role:

- **Data Gatherer:** A person responsible for the technical aspects of collecting, organizing, and/or sharing overdose-related data from another agency, program, or system, and serving as the primary point of contact between agencies and collaborative partners.
- **Liaison**: A person who maintains relationships between and among data-sharing organizations through communication, meeting facilitation, and other coordination efforts.
- **Data Analyst**: A person who looks at the data to identify trends and pulls out relevant information in the forms of charts, graphs, and other helpful visualizations.
- **Data Interpreter**: A person or group of people who discuss overdose-related data to identify trends, patterns, disparities, service gaps, and opportunities for prevention or intervention in a way that informs action. There are typically many interpreters with varying perspectives, including data analysts and outreach team members.
- **Decision Maker:** Those who use overdose-related data to guide outreach strategy, allocate resources, approve strategies, or implement operational and programmatic changes. This is typically members of the outreach team and may also include leadership at an organization.

FIELD TIP

Plan for participant compensation early.

Organizations often find that budgeting for participant compensation at the outset of surveys, focus groups, and other engagement activities helps reduce participation barriers, supports more representative feedback, and demonstrates that participants' time, expertise, and lived experience are valued. Compensation should be considered as part of the collection of active data whenever possible.

DATA TO ASSESS COMMUNITY OR COUNTY-LEVEL NEEDS

Data for community-based outreach should help teams understand **who is at highest risk**, **where and when outreach is needed**, **what barriers exist**, and **what strategies** are most likely to build trust with the people reached. The goal is not to collect data for its own sake, but to use information that helps outreach teams make better decisions about where to focus resources, how to engage people, and when to adjust their approach. Different data sources provide different perspectives, and no single source tells the whole story.

Effective outreach planning relies on combining quantitative data with what outreach workers, peers, harm reduction providers, and community members are seeing on the ground. Trends in overdose, health care utilization, or community indicators can help identify areas of concern, while field insight provides essential context about emerging risks, community dynamics, and barriers to engagement. These questions should be revisited regularly as conditions change. If a

data point does not help determine where, when, or how outreach should occur, it is likely not worth prioritizing. The most useful data are the data that inform action.

Data Domains	Questions data can answer	Which data sources do you use?
Overdose and Health Data	What are the trends and how do they change over time? Where are overdoses happening right now and when is outreach presence most critical? Are certain substances present that can inform tools, education, and harm reduction strategies? When does risk increase by time of day, day of week, month, or key event?	☐ Existing crisis response data ☐ EMS reports of overdose responses and/or naloxone administration events (may also be available through local law enforcement and/or High Intensity Drug Trafficking Area (HIDTA) ☐ Emergency Department (ED) chief complaint and discharge data coded for drug-related events ☐ Overdose mortality (Medical Examiner or Coroner) ☐ Toxicology trends in fatal overdose from the Medical Examiner/Coroner ☐ Drug checking results from harm reduction programs ☐ Community naloxone administrations
High-Risk Transition Data	Who is at highest risk by location, population, or transition point? Which populations need proactive, timely contact and follow-up?	☐ Local detention center intake and release timing/location ☐ Hospital/ED discharge timing ☐ Shelter encounter trends ☐ Prescription drug monitoring data ☐ Infectious disease tracking
Community and Field Data	What is happening right now? How is risk lived, what builds trust, and what works best? How should the data be interpreted and how should we adapt our strategies?	☐ Regular meetings with harm reduction and street medicine providers ☐ Insight gathered from peer recovery specialists, community health workers, or other organizations conducting outreach ☐ Community feedback gathered informally in conversations or through surveys ☐ Regular outreach debriefs

USE THIS TOOL

Looking for overdose surveillance data, resources, and support? Explore California Department of Public Health Overdose Prevention Initiative .

ADDITIONAL RESOURCES

Connecting Overdose Prevention Efforts (COPE) Data Dashboard – Community overdose reporting and outreach insights.

County Overdose Dashboards – Local overdose, healthcare utilization, and demographic data dashboards. Examples include dashboards developed in **San Diego County** and other jurisdictions.

ODMAP (Overdose Detection Mapping Application Program) – Real-time overdose surveillance and spike alert platform.

Spike Alert and Rapid Response Systems – Systems that notify partners of overdose spikes and support rapid outreach response.

USING PASSIVE AND ACTIVE DATA

Passive data identifies trends and hotspots. Active data helps explain community conditions, emerging risks, and barriers that may not yet appear in formal datasets. Teams should use both passive and active data collection to guide AFBSS planning and outreach decisions. Reviewing both types of data together ensures that outreach decisions are both grounded in data and responsive to what people are experiencing in real time.

	PASSIVE DATA	ACTIVE DATA
What it is	Retrospective review of routinely collected information.	New information and data gathered in the community.
How to use it:	Helps teams identify trends, patterns, and service gaps that may not be visible in the field.	Captures current community conditions, lived experience, and barriers to engagement.
Examples	– Admission, discharge and transfer (ADT) data.	– Surveys with open-ended questions, which allow for a

- Situational awareness and syndromic data.
- Health services data.
- Program evaluation metrics.
- Results from past assessments, surveys, or other study data.

variety of individualized responses.
- Focus groups.
- Individual interviews.
- Outreach notes and peer observations.

IDENTIFYING PRIORITY POPULATIONS

Identifying priority populations is an ongoing process that combines data, lived experience, and intentional equity checks to ensure outreach reaches those most at risk—especially those least visible in the data.

COMMON PRIORITY POPULATIONS FOR DATA-INFORMED OUTREACH

Use local data and field insight to identify priority populations for outreach. Start by looking for groups with elevated overdose risk, recent overdose or crisis events, high-risk transitions, limited access to treatment, or repeated barriers to engagement. Then compare the data with what outreach teams, peers, harm reduction providers, and community partners are seeing in real time. Priority populations may include:

- **Eligible for housing interventions services, including at-risk of homelessness, experiencing homelessness, or chronically homeless with a focus on those in encampments.**
- **Children and youth who are:**
  - In, or at risk of being in, the juvenile justice system;
  - Reentering the community from a youth correctional facility;
  - In the child welfare system; or
  - At risk of institutionalization.
- **Adults or older adults who are:**
  - In, or at risk of being in, the justice system;
  - Reentering the community from prison or jail;

FIELD TIP

Data-informed outreach is not only a strategy for identifying who to engage, but also a way to evaluate whether outreach efforts are reaching priority populations, connecting individuals to services, and reducing barriers to care. Teams should regularly review outreach and engagement data to inform continuous quality improvement.

See the section on Quality Improvement and Measuring Success in Section 5: Clinical Practice and Service Delivery in AFBSS.

- At risk of conservatorship; or
- At risk of institutionalization.

APPLYING AN EQUITY LENS

An equity lens encourages us to ask not only *who is visible in the data*, but also *who may be missing and why*. Equity-focused data review considers both what the data shows and how lived experience, historical context, and community knowledge shape interpretation and decision-making.

Consider the following questions during planning and data review:

- **Who is represented—and who is missing?** Which populations appear most frequently in outreach or surveillance data, and which populations are less represented or not showing up at all?
- **What barriers may affect visibility or engagement?** Are language, trust, disability, immigration status, transportation, or prior system harm influencing who is reflected in the data or who engages with services?
- **Where might data gaps influence decision-making?** Are certain neighborhoods, communities, or populations consistently underrepresented because of limitations in available data?
- **Whose perspectives are shaping interpretation?** How do the backgrounds, experiences, and perspectives of those collecting, analyzing, and interpreting data influence outreach priorities and decisions?
- **How does lived experience inform outreach design?** Are outreach teams, peers, and community partners helping interpret findings and identify strategies that reflect current community realities?
- **Are outreach teams representative of the communities they serve?** Consider the diversity of outreach staff, the relevance of lived experience, and how historical and community context may influence trust and engagement.

FIELD TIP

Challenge assumptions about who may be at risk of overdose.

Biases and stereotypes can create dangerous blind spots that cause people to be overlooked for overdose prevention education, naloxone access, and care. Research shows that women, older adults, and people without obvious signs of opioid use disorder are less likely to receive naloxone and may face higher overdose death rates as a result.

In AFBSS, equity considerations should be integrated into every discussion, but it can be helpful for teams to periodically pause and focus specifically on equity.

USE THIS TOOL

Ready to have an equity-focused data conversation? Use the Applying an Equity Lens to Data-Informed Outreach. > **Tool 3.A**

ADDITIONAL RESOURCES

California Health and Human Services Agency (CalHHS) Open Data Portal – County-level health, human services, and SUD datasets.

California Health and Human Services (CHHS) Program Dashboard – County-level program participation, overlays, and equity indicators.

Integrating Community and Lived Experience

A way to mitigate equity barriers is to integrate community and lived experience early in the process.

- **Peer and Frontline Interpretation:** Ask peers and outreach teams to interpret data trends.
- **Validation of Priority Populations:** Validate whether identified priority populations align with on-the-ground realities.
- **Qualitative Insight and Emerging Risks:** Use qualitative input to surface risks not yet reflected in quantitative data.

TURNING DATA INTO OUTREACH DECISIONS

Collecting data is only valuable if it informs action. Effective data-informed outreach combines quantitative data, lived experience, community knowledge, and frontline observations to determine **who should be prioritized, where outreach should occur, when engagement is most needed, and how teams should respond**. The following approaches help translate information into practical outreach decisions while ensuring strategies remain responsive to changing community conditions.

LAYERING QUANTITATIVE AND QUALITATIVE DATA SOURCES

Effective identification of communities at risk relies on multiple data sources reviewed together. No single data source is sufficient on its own. Patterns become clearer when data is layered, validated, and interpreted with local knowledge. Layering data means reviewing different data sources side-by-side—rather than combining them into a single system or dataset. This approach preserves privacy, reduces administrative burden, and keeps outreach decisions grounded in real-time conditions.

FIELD TIP

Layering data does not require building a single dataset or dashboard. Reviewing multiple sources side-by-side can provide enough information to guide outreach.

Layering supports action—even when no single data source is perfect.

1. **Identify relevant data sources** to build a more complete picture of risk from multiple perspectives. Start by gathering multiple sources that reflect overdose risk, service utilization, and community conditions. No single dataset tells the full story.
   - Overdose surveillance data.
   - EMS calls.
   - Emergency department visits.
   - Jail release data.
   - Shelter and homelessness data.
   - Community partner observations.
2. **Look for patterns and overlap** to identify where outreach is most likely to have the greatest impact. Review data sources side-by-side to identify where multiple indicators point to the same populations, locations, or trends.
   - Overdose activity and EMS calls occurring in the same area.
   - Jail releases aligning with increased overdose activity.
   - Repeated risk signals within a neighborhood or ZIP code.
3. **Validate findings with local knowledge** to ensure data-driven decisions are grounded in community context. Use input from peers, outreach teams, and community partners to determine whether identified patterns align with on-the-ground realities.
   - Confirming emerging hotspots.
   - Understanding seasonal shifts.
   - Identifying risks not yet reflected in quantitative data.
4. **Prioritize and adjust outreach strategies** to translate data into targeted, responsive outreach actions. Use the combined information to determine where, when, and how outreach should occur.
   - Deploying outreach to specific locations.
   - Adjusting timing based on community activity patterns.
   - Using peer-led engagement.

CREATING CROSS-SYSTEM DATA TOUCHPOINTS

Cross-system data touchpoints connect insights across departments without requiring shared databases, new technology platforms, or data integration. The goal is **to create regular**

opportunities for partners to share information, identify emerging risks, and coordinate outreach strategies while maintaining data ownership and privacy protections.

- **Hold Regular Data Briefings**
  - Create recurring opportunities to review trends, identify emerging issues, and discuss implications for outreach.
  - Consider monthly cross-department huddles or briefings following overdose spikes.
- **Identify Data Liaisons**
  - Designate a point person within each department or partner organization.
  - Liaisons share relevant insights, flag emerging issues, and support coordination across systems.
- **Use Shared Definitions**
  - Agree on common terms such as “post-overdose follow-up,” “outreach attempt,” and “connection to services.”
  - Shared language improves coordination even when partners use different systems and data sources

PEER + DATA REVIEW WORKSHEET

Data and dashboards can help identify patterns, but they rarely explain the full story. Effective outreach decisions require both quantitative data and the insights of people who know the community best. This worksheet is designed to help teams review data alongside peer, outreach, and community perspectives to identify emerging risks, validate findings, and determine where, when, and how outreach should occur.

Use this worksheet during team huddles, outreach planning meetings, overdose response reviews, or cross-system data briefings. It supports the key concepts described in this chapter, including layering multiple data sources, incorporating lived experience into decision-making, applying an equity lens, and creating feedback loops that continuously improve outreach strategies.

USE THIS TOOL

Ready to use data and team input to inform your strategy? Use the Peer + Data Review Worksheet.

> **Tool 3.B**

LEARNING AND ADAPTING

Data-informed outreach is an ongoing process. Community conditions, substance use patterns, service availability, and population needs can change quickly. Effective outreach teams use data, field observations, peer perspectives, and community feedback to continuously assess what is happening, identify emerging risks, and adjust outreach strategies over time.

The goal is not to collect more information, but to use available information to strengthen outreach decisions, improve responsiveness, and better meet community needs.

FEEDBACK LOOPS

Feedback loops help ensure that information gathered during outreach informs future planning and decision-making. While data can help identify where outreach is needed, outreach teams, peers, and community members often provide the context needed to understand emerging trends, barriers, and changing community conditions.

Effective feedback loops create regular opportunities to:

- **Share frontline observations:** Capture what outreach teams are seeing, hearing, and experiencing in the field.
- **Integrate peer and community perspectives:** Elevate lived experience and community knowledge alongside quantitative data.
- **Identify emerging risks and trends:** Monitor changes in substance use patterns, overdose risk, service gaps, and community conditions.
- **Evaluate outreach strategies:** Assess what is working, what is not, and where adjustments may be needed.
- **Inform future outreach decisions:** Use feedback to refine who is prioritized, where outreach occurs, and how services are delivered.

When routinely reviewed, feedback from the field helps ensure outreach remains responsive, trusted, and grounded in current community realities.

WHAT TO SHARE FROM THE FIELD

- **Outreach Team Observations:** What outreach staff are seeing, hearing, and experiencing in the field.
- **Peer Perspectives:** Insights from individuals with lived experience about emerging trends, barriers, and community needs.
- **Community and Participant Feedback:** Non-identifying feedback about outreach experiences, service needs, and engagement challenges.
- **Data and Trend Reviews:** Hot spots, timing patterns, emerging risks, and changes in community conditions.

CONSIDER THIS

Teams find that when outreach staff can see how their perspectives influenced decisions, engagement strengthens, communication improves, and they are more likely to view themselves as partners in shaping the work rather than simply carrying it out.

Instead of: Forgetting to close the loop with outreach teams on the impact of their feedback.

Try this: Close the loop by sharing how outreach team feedback informed decisions, shaped priorities, or influenced strategy.

USE THIS TOOL

Ready to gather field notes from outreach workers? Use the Outreach Field Notes Worksheet.

> Tool 3.C

BUILDING ON EXISTING REPORTING PROCESSES

Most California counties already collect outreach-related information for reporting, reimbursement, surveillance, or program management purposes. Common examples include:

- **Activity and Encounter Tracking:** Outreach contacts, encounter counts, and service delivery activities.
- **Location and Population Trends:** Outreach activity by geography, setting, or population group.
- **Narrative Field Notes:** Qualitative observations, emerging concerns, and community feedback.
- **Supply Distribution Tracking:** Naloxone distribution, harm reduction supplies, and other outreach resources.
- **Health Information Exchanges (HIEs):** Emergency department visits, hospitalizations, discharges, and other care transitions to support outreach and follow-up.

The opportunity is often not to collect more information, but to use existing data and field observations together to support timely outreach decisions.

REPORTING FOR LEARNING, NOT BUREAUCRACY

Reporting is most valuable when it supports learning and coordination—not paperwork. Coordinated reporting helps create a shared picture of community need and response and supports accountability to funders, counties, and communities.

Good reporting enables:

- Shared understanding of patterns and trends.
- Identification of root causes and emerging risks.
- Discussion of implications for outreach practice.
- Agreement on what adjustments are needed.

FIELD TIP

Review reports together and explore what the information may mean in practice.

- ☐ **What stands out?** Patterns, changes, or unexpected findings?
- ☐ **What might be contributing to this pattern?** Community factors, service changes?
- ☐ **What action should we consider?** What needs additional attention or monitoring?

SECTION 3 KEY TAKEAWAYS & RESOURCE MAP

- **Data + Community Insight:** Data-informed outreach combines quantitative data, lived experience, and community knowledge.
- **Inform Outreach Decisions:** Data helps identify who is at risk, where outreach is needed, and how strategies should be adapted.
- **Use Multiple Sources:** Multiple sources should be reviewed together.
- **Prioritize with Equity in Mind:** Priority populations should be identified using data, equity considerations, and community input.
- **Interpret Data with Context:** Outreach decisions are strongest when data is interpreted alongside field observations and peer expertise.
- **Continuously Learn and Adapt:** Feedback loops help teams respond to changing conditions and improve outreach effectiveness over time.

IF YOU ARE READY TO...	GO TO...	
Identify overdose surveillance data, resources, and support	>	**Resource** California Department of Public Health Overdose Prevention Initiative

Identify equity gaps and strengthen outreach planning	>	**Tool 3.A**	Applying an Equity Lens to Data-Informed Outreach
Use data and team input to guide outreach decisions	>	**Tool 3.B**	Peer + Data Review Worksheet
Capture observations and feedback from the field	>	**Tool 3.C**	Outreach Field Notes Worksheet

REFERENCES

California Health and Human Services Agency. (2026). *CalHHS open data portal: County-level health, human services, and substance use disorder datasets*. https://data.chhs.ca.gov/

California Health and Human Services Agency. (n.d.). *CHHS program dashboard: County-level program participation, overlays, and equity indicators*. https://californiatoday.com/health-chhs-program-dashboard/

Centers for Disease Control and Prevention. (2024). *Overdose Data to Action: Surveillance strategies*. https://www.cdc.gov/overdose-prevention/php/od2a/surveillance.html

National Harm Reduction Coalition. (n.d.). *National Harm Reduction Coalition*. https://harmreduction.org/

Washington/Baltimore High Intensity Drug Trafficking Area. (n.d.). *Overdose detection mapping application program (ODMAP)*. https://odmap.org/

SECTION 4:
STAFFING, WORKFORCE CAPACITY, AND TRAINING

PURPOSE

This section provides guidance on building, supporting, and sustaining the workforce needed to deliver Assertive Field-Based Substance Use Disorder Services (AFBSS).

Successful AFBSS implementation requires a **multidisciplinary workforce with the skills and support needed** to engage individuals in community settings, coordinate care, and respond to changing needs over time. Effective AFBSS relies on **mobile, multidisciplinary teams organized around shared responsibility** for engagement, stabilization, treatment, and care coordination. Staffing should be aligned to the functions needed to support individuals in the community rather than specific disciplines alone.

Because AFBSS is relationship-based and trust-driven, consistent team composition, workforce stability, and continuity of care are critical to successful engagement and long-term outcomes.

HOW TO USE THIS SECTION

This section focuses on **workforce planning, multidisciplinary staffing models, peer integration, training, and supervision**. As you review the content, consider:

- ☑ How should our workforce be structured to support the core functions of AFBSS?
- ☑ How are peer support workers and multidisciplinary team members integrated into service delivery and care coordination?
- ☑ How should staffing, caseloads, and coverage models be adapted to local needs, acuity, and available resources?
- ☑ What training, supervision, and workforce supports are needed to sustain high-quality field-based services?

Throughout this section, you'll find staffing considerations, workforce tools, and training resources. These tools can help you **build, support, and sustain an effective AFBSS workforce**.

STAFFING COMPOSITION

AFBSS staffing is most effective when multidisciplinary, mobile teams function as a unit with shared responsibility for engagement, care delivery, and coordination. Staffing should be organized around the functions needed to support individuals in the community, with roles filled through full-time, part-time, or combined positions based on program size and resources.

CORE ROLES

- Clinical Lead (Psychiatrist, Licensed Clinical Social Woker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC))
- Substance Use Disorder (SUD) Counselor or Specialist
- Prescriber (Nurse Practitioner (NP), Physician Assistant (PA), or Doctor of Medicine (MD or DO))
- Care Coordinator / Case Manager
- Peer Support Worker (see below)
- Outreach / Field Engagement Specialist

EXTENDED ROLES (AS AVAILABLE)

- Behavioral Health Clinician (co-occurring mental health)
- Nurse (Registered Nurse (RN) or Licensed Vocational Nurse (LVN)) (patient education, health promotion, chronic health conditions, wound care, infectious disease)
- Housing Navigator
- Data and Quality Support Staff

Integration of Peers and Lived Experience

Peer workers are central to AFBSS success. AFBSS programs should position peer workers as core members of the workforce, supporting engagement, continuity, recovery, and culturally responsive care. **Peer workers are individuals with lived experience of substance use and/or mental health conditions who are trained to support others in recovery.** In California, Peer Support Specialists (PSS) are recognized through the Medi-Cal Peer Support Services benefit and certified at the state level.

FIELD TIP

Treat peer workers as core team members, not supplemental staff.

Peer workers are most effective when actively involved in outreach, team huddles, care planning, follow-up, training, and team decision-making.

Peer workers should be fully integrated into team operations and service delivery. They contribute unique expertise grounded in lived experience that can help build trust, increase engagement, reduce stigma, and support recovery in ways that complement clinical services.

Their specific contributions include tailoring person-centered engagement strategies, maintaining relationships with clients, and participating in care planning with the team. Peer workers are not an add-on to the treatment team; they are a critical component of successful field-based care models.

Key functions of peers

- Identify client needs and assist in translating care needs.
- Initiate and sustain engagement.
- Build trust and rapport.
- Support harm reduction, recovery planning, and self-determination.
- Support health promotion and wellness activities.
- Assist with navigation of health, behavioral health, housing, and social service systems.
- Maintain connection during periods of disengagement.
- Serve as bridge between individuals and broader care team.

Peer Integration Checklist

Integrating peers requires intentional team design, not just hiring.

- ✓ Develop clear peer role descriptions, responsibilities, and workflow expectations.
- ✓ Provide topic specific training that is complimentary to peer workers' existing certification requirements.
- ✓ Include peer workers in daily team huddles.
- ✓ Integrate peer workers into shared caseload management and service delivery.
- ✓ Involve peer workers in care planning.
- ✓ Provide peer workers with structured supervision and professional support.
- ✓ Establish clear career pathways and advancement opportunities for peer workers.
- ✓ Share peer success stories and outcomes to reinforce the value of lived experience.

Beyond Hiring: Creating the Conditions for Successful Peer Integration

Integrating peer workers requires more than creating positions. Organizations should assess their readiness to support peer roles through leadership commitment, supportive policies, effective supervision, and workforce culture. Leadership should communicate the value of lived experience, address stigma related to substance use disorders, and ensure peer workers are viewed as professional care team members. Organizations should intentionally prepare staff, develop workflows, and create systems to integrate peers.

? REFLECT ON IT

How does leadership communicate the value of lived experience?

How effectively are peers integrated into team workflows and service delivery?

If peer workers were asked about their experience on the team, would they feel respected, supported, and empowered to contribute? Why or why not?

Role definition is equally important. Peer workers should not be used as administrative support or expected to fulfill clinical responsibilities outside their scope. Peer workers should have clearly defined responsibilities, provided appropriate boundary parameters, and a contributing role on the team. Clear expectations help maximize their strengths in outreach, engagement, advocacy, recovery support, and navigation while reducing confusion and role drift.

Supervision Support for Peers

In addition to operational guidance, peer workers benefit from reflective supervision that supports professional growth, maintaining wellness, clarifying boundaries and most importantly, guidance as to how peers' lived experience can best inform and enhance the work.

Supervisors should understand the peer role, advocate for respectful team integration, model person-centered and recovery-oriented practices, and provide opportunities for feedback, coaching, and skill development. Organizations may also consider group supervision or peer-to-peer support opportunities to strengthen team cohesion and reduce workforce isolation.

FIELD TIP

Invest in Reflective Supervision

Peer workers benefit from more than task-focused supervision. Regular reflective supervision creates space to discuss boundaries, wellness, professional growth, and the use of lived experience. Consider pairing individual supervision with peer support or group supervision opportunities to reduce isolation and strengthen team connection.

ADDITIONAL RESOURCES

Medi-Cal Peer Support Services Specialist Program: Frequently Asked Questions – Guidance from the California Department of Health Care Services outlining Medi-Cal peer support requirements, certification information, covered services, and implementation considerations for peer workforce integration.

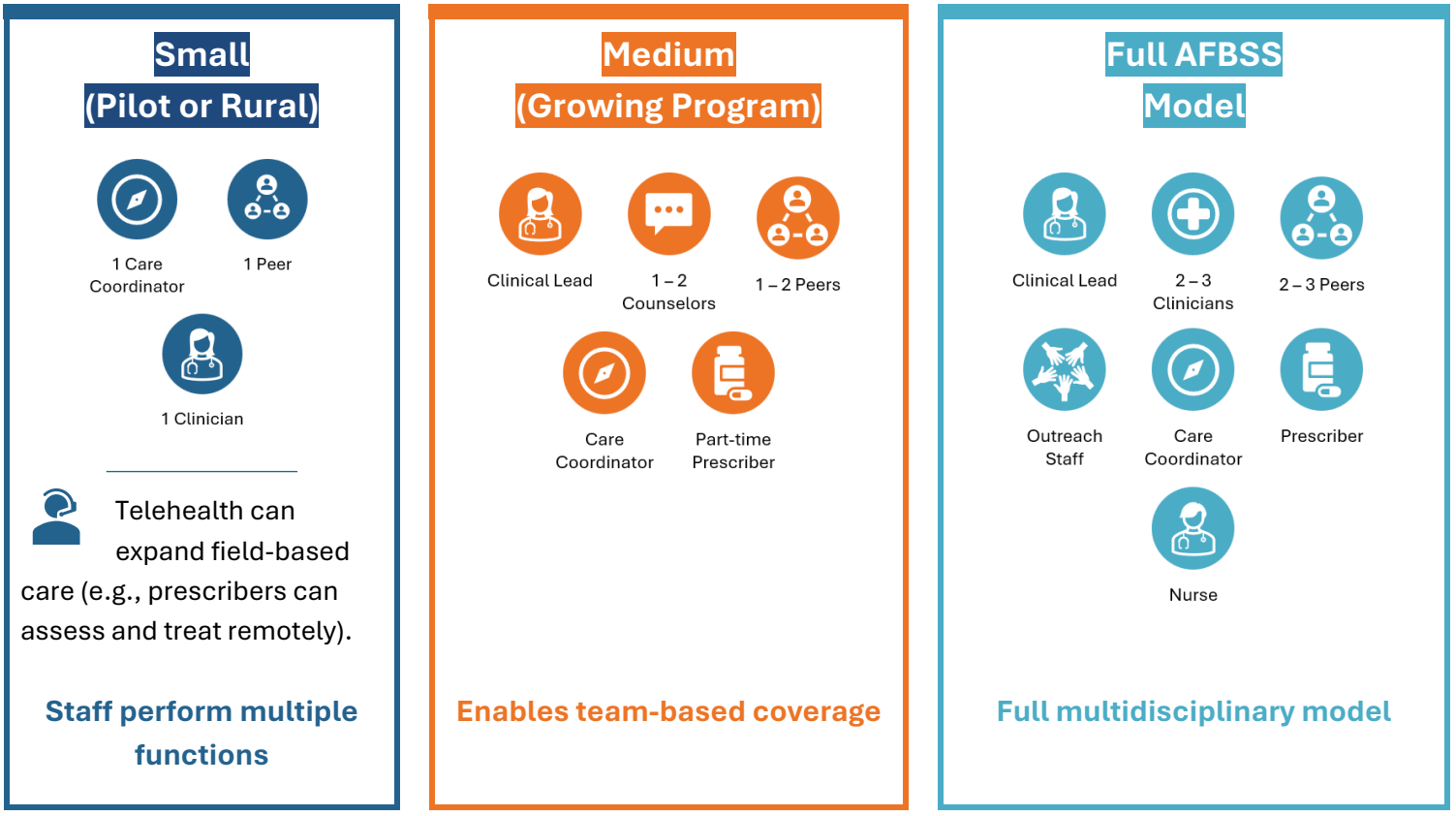
Peer Recovery Support Specialists: An Overview of the Evidence and Key Considerations for State Substance Use Disorder Systems – A national resource summarizing the evidence base for peer support services and offering considerations for recruiting, integrating, supervising, and sustaining peer support specialists within SUD treatment systems.

SAMHSA TIP 64: Incorporating Peer Support Into Substance Use Disorder Treatment Services –guidance on integrating peer workers into SUD treatment programs.

STAFFING MODEL BY PROGRAM SIZE

A core principle of AFBSS workforce design is to ensure coverage of outreach and engagement, treatment, harm reduction, monitoring and coordination of referrals and linkages. These models

illustrate how programs can scale staffing based on size and resources. They are examples, not minimum staffing requirements, and should be adapted to local context.



USE THIS TOOL

Ready to evaluate workforce opportunities? Use the AFBSS Team Self-Assessment Tool. > **Tool 4.A**

CASELOAD CONSIDERATIONS

Caseloads should reflect the intensity, complexity, and unpredictability of field-based work, rather than traditional clinic productivity models. Evidence-based field models support **lower caseloads for high-acuity populations and the variability of outside work**. These ranges are practice-informed planning benchmarks, not productivity targets, and should be adjusted based on geography, staffing mix, training and service intensity.

ALIGNING TEAM EFFORT TO ACUITY LEVEL

In team-based, field-oriented models, acuity determines care delivery effort required for that client. Acuity determines how the team organizes its work interventions, the number of staff in the team, staffing, supplies, training needs and overall panel size (i.e., the number of clients the team can safely manage). Higher acuity requires more intensive, coordinated, and multi-

disciplinary involvement, while lower acuity allows for more targeted and efficient engagement. Evaluating and addressing acuity and work effort is an important activity that reduces team fatigue and burnout.

For more information on assessing the acuity level of individuals served (including a worksheet), see Understanding Acuity, Risk, And Complexity in Section 2: Understanding Individuals Served Through AFBSS in this toolkit.

CASELOAD GUIDANCE

Staff capacity must account for:

- Travel and outreach.
- Care delivery and coordination.
- Documentation.
- Team consultation.

Caseloads should be team-based rather than individually assigned, allowing multiple staff to engage each individual as needed and provide different skills.

FIELD TIP

The following capacity ranges provide general guidance for aligning team-based caseloads with client acuity.

High-acuity Individuals

10–15 clients per full-time employee (FTE)

Moderate-acuity Individuals

20–25 clients per FTE

CASELOAD PLANNING FRAMEWORK

Purpose: To guide staffing decisions by aligning caseload size and team capacity with the size, acuity, and service needs of the population.

STEPS

1. **Estimate** the number of clients to be served.
2. **Define** the acuity mix of the population.
3. **Apply** capacity assumptions.
4. **Calculate** staffing needs.

EXAMPLE CALCULATION

A program serving 60 clients, with an even split (30 high-acuity, 30 moderate-acuity), could calculate staffing as follows:

Acuity Level	# of Clients	Capacity Assumption (Midpoint)	Calculation	FTE
High	30	12 clients per FTE	30÷12	≈ 2.5 FTE
Moderate	30	22 clients per FTE	30÷22	≈ 1.4 FTE

Estimated total staffing need ≈ 4 FTE

STAFF COVERAGE AND CONTINUITY PLANNING

AFBSS programs must ensure continuous access and consistent engagement, particularly for high-risk individuals. This requires moving from individual caseload ownership to team-based coverage models, supported by structured workflows and shared accountability.

FIELD TIP

Clients should know the team, not just one staff member.

Programs often find that shared caseloads and clear coverage plans improve continuity and reduce service disruptions when staff are absent or roles change.

PROGRAM COVERAGE APPROACHES

The table below describes common coverage models and how responsibility for clients is structured across the team to support continuity of care, access, and coordination of care.

COMMON COVERAGE MODELS

Model	Description	When to Use
Shared Caseload	The full team shares responsibility for all clients, allowing flexible response and continuity of care.	Preferred model for team-based care, especially for high-acuity populations.
Primary and Backup	A primary staff member leads care, with a designated backup for coverage.	Smaller teams or early-stage programs building toward shared models.
Geographic Coverage	Staff are assigned based on location or region.	Rural or geographically dispersed service areas where travel efficiency is critical.
On-Call Rotation	Staff rotate responsibility for after-hours or crisis response.	Programs serving high-risk populations requiring 24/7 access.

DAILY COVERAGE AND TEAM OPERATIONS

Teams must operationalize coverage on a day-to-day basis to ensure consistency, coordination, and access to care. Key practices include:

- **Daily team huddle:** Align priorities, review client needs, and coordinate outreach.
- **Designated outreach blocks:** Protect time for proactive engagement and field-based care.

- **Rotating crisis response role:** Assign daily responsibility for urgent needs and real-time response.
- **Scheduled follow-up and coordination time:** Scheduled time for follow-up, care coordination, and referral management.
- **Protected documentation time:** Support accurate, timely documentation and team communication.

ALIGNING THE MODEL TO LOCAL NEEDS AND RESOURCES

AFBSS staffing and service delivery models should reflect the needs of the populations being served, available workforce capacity, and local community context. Different communities may organize services differently, but all AFBSS models should support timely access, relationship-based engagement, coordinated care, and continuity over time.

REFLECT ON IT

How can we adapt staffing and service delivery to our local conditions while maintaining the core functions of AFBSS?

Local Need or Consideration	Potential Adaptations
High-Acuity Or Unsheltered Populations	Prioritize outreach capacity, peer support, and lower caseloads to support intensive engagement.
Medically Complex Populations	Include nursing, prescribing, and care coordination capacity.
Geographically Dispersed Populations	Use hybrid, regional, telehealth, or hub-and-spoke models.
Limited Workforce Capacity	Start with a small multidisciplinary team, cross-train staff, prioritize peer-clinician partnerships, and scale staffing over time.

Across all models, the goal is to ensure:

- Timely and consistent access to services.
- Persistent, relationship-based engagement.
- Integrated clinical, behavioral health, medical, and social service supports.
- Coordinated care over time.

CONSIDERATIONS FOR RURAL AND FRONTIER PROVIDERS

Implementing this model in rural or frontier settings is not about scaling it back; it is about adapting it to fit local realities. Rural and frontier communities often operate across large

geographic areas and may rely on creative strategies to address workforce capacity, transportation challenges, internet connectivity limitations, weather and road conditions, access to community resources, and availability of MAT-trained prescribers. In tribal, frontier, and other remote contexts, partnerships with regional providers and community-based organizations are especially important.

The table below provides practical strategies to address common rural and frontier challenges while preserving the integrity of the AFBSS model.

ADAPTATION STRATEGIES FOR RURAL & FRONTIER COMMUNITIES

Implementation Consideration	Adaptation Strategies
Workforce Capacity	Crosstrain staff to perform multiple functions; use telehealth and technology to extend team capacity; develop internship, externship, and residency programs; leverage Workforce Education and Training (WET) funding; partner regionally to share specialized staff.
Large Geographic Service Areas	Establish mobile outreach hubs; use scheduled outreach routes; coordinate services around existing community gathering locations; use telehealth for follow-up and care coordination; cluster outreach activities geographically to maximize travel time.
Limited Access to MAT Prescribers	Develop telehealth prescribing partnerships; use hub-and-spoke models; partner with regional health systems and federally qualified health centers; establish referral pathways for medications not available locally.
Transportation and Travel Considerations	Bring services directly into communities through mobile teams; coordinate transportation support when available; combine outreach, treatment, and follow-up services into a single visit; use telehealth when appropriate.
Connectivity Limitations	Use hybrid service models; maintain paper-based workflows when needed; equip teams with offline documentation and communication options; identify community locations with reliable connectivity for telehealth access (e.g., libraries).
Weather and Seasonal Access Challenges	Develop contingency plans for severe weather; adjust outreach schedules seasonally; use telehealth and phone-based follow-up when travel is unsafe; coordinate with local partners who can maintain a community presence during access disruptions.
Limited Local Resources	Strengthen referral networks; build partnerships across sectors; leverage regional collaborations and shared services; maximize use of

	peer supports, community-based organizations, and existing infrastructure.
Workforce Isolation	Conduct regular virtual team huddles and supervision; create opportunities for peer consultation and case review; participate in regional learning collaboratives; use technology to maintain connection across dispersed teams.

ADDITIONAL RESOURCES

California Rural Health Transformation (CalRHT) Initiative – A statewide resource that supports rural communities in strengthening healthcare infrastructure, workforce capacity, care coordination, and regional partnerships. For rural and frontier AFBSS programs, CalRHT planning processes can provide opportunities to elevate behavioral health and SUD priorities, strengthen cross-sector collaboration, and identify resources that support sustainable field-based service delivery. Learn more about CalRHT.

COMMON STAFFING PITFALLS AND HOW TO AVOID THEM

Building and sustaining an effective AFBSS workforce requires more than filling positions. Many implementation challenges stem from how teams are structured, supported, trained, and integrated. The following examples highlight common workforce pitfalls and practical strategies organizations can use to strengthen engagement, improve team functioning, and support long-term workforce stability.

WORKFORCE RISKS, IMPACTS, AND MITIGATION STRATEGIES

Risks	Potential Impact	Mitigation Strategy
Over-reliance on clinicians for outreach and engagement	Reduced capacity; weaker engagement and relationship-building	Use peers and other outreach staff as primary engagement leads, with clinicians supporting treatment and consultation as needed.
Underutilizing peer workers	Missed opportunities for trust-building, engagement, and retention	Fully integrate peer workers into outreach, care planning, follow-up, and team decision-making.
Unrealistic productivity expectations	Burnout, turnover, reduced field presence, and lower-quality engagement	Set expectations that reflect the realities of field-based, relationship-driven work.

Risks	Potential Impact	Mitigation Strategy
No coverage or continuity plan	Client disengagement, missed follow-up, and disruptions in care	Use shared caseloads, team-based care, and clear handoff procedures.
Siloed roles and responsibilities	Fragmented care and inconsistent communication	Establish team-based workflows, regular huddles, and shared accountability for outcomes.
Lack of role clarity	Duplication of effort, confusion, and team friction	Clearly define responsibilities while maintaining flexibility for team-based care.
Inconsistent training or overreliance on web-based training	Staff may feel underprepared for community-based work and complex situations	Provide ongoing, experiential training, shadowing opportunities, coaching, and skill reinforcement.
Inconsistent supervision and team support	Burnout, turnover, team conflict, and inconsistent practice	Provide regular supervision, reflective practice, mentoring, and opportunities for case consultation.
High staff turnover	Disrupted relationships and loss of trust with participants	Invest in retention, onboarding, mentoring, and succession planning.
Insufficient time for relationship-building	Lower engagement, reduced treatment uptake, and weaker continuity of care	Structure caseloads and productivity expectations to support outreach, engagement, and follow-up.

TRAINING, SUPERVISION, AND RETENTION

AFBSS staff require training that goes beyond initial onboarding. Skills must be reinforced and adapted over time to reflect the realities of outreach, engagement, care delivery and working with individuals with complex needs. Training should be evidence-based, practical, applied, iterative and reinforced through supervision and team-based learning, rather than delivered as one-time events. AFBSS programs should establish systems that support:

- Continuous skill development.
- Reflective and clinical supervision.
- Staff well-being and retention.

USE THIS TOOL

Ready to evaluate workforce strengths, identify support needs, and reduce burnout risk? Use the Training, Supervision, and Workforce Retention Checklist.

> Tool 4.B

SKILL DEVELOPMENT & TRAINING

AFBSS staff (regardless of role) need a broad set of skills to effectively engage, treat, and coordinate care for individuals with complex needs in community settings. Training should extend beyond initial onboarding and be reinforced through coaching, supervision, and ongoing practice. The goal is to build workforce confidence, competence, and consistency while supporting high-quality, field-based care.

ADDITIONAL RESOURCES

Workforce Education and Training (WET) Resources – BHSA-funded workforce development guidance and funding opportunities that can support recruitment, training, retention, and workforce sustainability efforts.

Core training areas

Core training should focus on the skills required to effectively engage, treat, and coordinate care for individuals with complex needs in field-based settings. This might include:

- Motivational Interviewing (MI).
- Harm reduction approaches.
- Medications for Opioid Use Disorder (MOUD).
- Trauma-informed care.
- Co-occurring mental and physical health conditions.
- Field safety and de-escalation.
- Care coordination, closed looped referral, and system navigation.
- Community Resources.
- First Aid, CPR and emergency response.
- Medi-Cal Insurance basics.
- AFBSS technology.

USE THIS TOOL

Interested in exploring trainings for AFBSS teams? Use the Mobile Field-Based SUD Services Training Curriculum for a Multidisciplinary Team.

> Tool 4.C

CLINICAL AND REFLECTIVE SUPERVISION

Supervision in AFBSS must address both clinical decision-making and the relational, emotional demands of the work. Both clinical and reflective supervision are essential to maintain quality, consistency, and staff resilience in field-based settings. Clinical and reflective supervision are most effective when used together. Together, they help teams deliver care that is both technically sound and relationship centered.

- **Clinical supervision** supports the delivery of safe, effective care. It focuses on assessment, treatment planning, risk management, and the appropriate use of evidence-based interventions. In AFBSS, clinical supervision also includes guidance on working in non-traditional settings, coordinating across systems, and responding to high-risk situations such as overdose or crisis events. Supervisors use case review, documentation review, and direct coaching to ensure that care is consistent, appropriate, and aligned with best practices.
- **Reflective supervision** supports the relational and emotional aspects of the work. It provides a structured space for staff to process challenging interactions, examine their responses, and build self-awareness. In AFBSS, where staff regularly engage with individuals experiencing trauma, instability, and crisis, reflective supervision helps staff manage stress, avoid burnout, and sustain engagement over time. It also strengthens relationship-based care by helping staff consider how their communication, assumptions, and reactions impact interactions with individuals and the team.



Supervision Structure

Supervision should be scheduled, protected, and prioritized, not treated as optional or secondary to service delivery. AFBSS programs should establish a consistent supervision model that includes:

- Regular individual supervision (clinical focus).
- Group or team supervision (case-based discussion and shared learning).
- Reflective supervision sessions (processing and support).
- Field-based coaching, when possible.

Supervisor Training and Support

Supervisors play a critical role in translating the AFBSS model into daily practice. Many supervisors, however, may not have prior experience with field-based, team-driven care models, and require targeted support.

Key supervisor competencies include:

- Supporting team-based care and shared caseloads.
- Coaching staff in engagement and outreach strategies.
- Integrating peers effectively into the team.
- Balancing clinical oversight with reflective support.
- Managing staff safety and field-based risk.

Supervisor Development and Supervision Strategies

High-quality AFBSS supervision requires more than clinical oversight. Supervisors must be equipped to support team-based care, field-based decision-making, and staff working with high-acuity populations. The strategies below outline key supports supervisors need and how they can integrate them into routine supervision practice.

- **Provide initial training on AFBSS model expectations:** Ensure supervisors understand the core components of AFBSS, including team-based care, shared caseloads, outreach expectations, and integration of peers. This training should prepare supervisors to translate the model into daily team practice.
- **Offer ongoing coaching or consultation for supervisors:** Supervisors benefit from regular access to coaching or consultation to navigate complex cases, team dynamics, and implementation challenges. This may include internal leadership support or external technical assistance.

- **Create opportunities for peer learning across supervisors:** Establish forums for supervisors to share challenges, strategies, and lessons learned. Peer learning supports consistency across teams and reduces isolation, particularly in smaller or rural programs.
- **Use case review and real-time problem-solving as learning tools:** Incorporate case-based discussion into supervision to reinforce skills, support decision-making, and connect training to real-world scenarios. Use current cases to guide discussion on engagement strategies, risk response, and care coordination.

SUPPORTING STAFF WELL-BEING AND RETENTION

AFBSS work can be emotionally demanding and unpredictable, particularly when working with individuals experiencing crisis, instability, trauma, or repeated setbacks. Staff may experience stress, compassion fatigue, secondary trauma, moral distress, and burnout if adequate supports are not in place. Workforce well-being is not solely an individual responsibility; organizations play a critical role in creating environments that promote resilience, support retention, and sustain high-quality care.

CONSIDER THIS

Many programs find that workforce sustainability is influenced as much by organizational supports as by individual coping strategies.

Instead of: Treating burnout as an individual resilience issue.

Try this: Build team structures that support reflection, backup coverage, supervision, and peer support.

Strong supervision, realistic expectations, supportive team culture, and opportunities for professional growth are important protective factors that help staff remain engaged and effective over time.

Programs should proactively support staff through:

- **Supportive supervision and workforce wellness:** Reflective supervision, opportunities to process challenging experiences, and regular conversations about stress, burnout, compassion fatigue, and workforce wellness.
- **Sustainable workloads:** Reasonable caseload expectations that reflect the realities of field-based work.
- **Team connection and support:** Team-based support structures, case consultation, peer learning, and supportive communication practices.
- **Recognition and resilience:** Recognition of the emotional labor involved in outreach and engagement work, along with training on self-awareness, stress management, burnout prevention, and resilience-building strategies.
- **Leadership and organizational support:** Clear expectations, role clarity, and leadership practices that encourage staff to ask questions, communicate concerns, and seek help

when needed. Organizations should actively address workplace stressors and create environments where staff feel supported and valued.

- **Growth and retention:** Opportunities for career growth, skill development, professional advancement, and ongoing learning.

Organizations should also regularly assess workforce well-being and identify factors contributing to stress, burnout, turnover, or moral distress. Creating opportunities for staff feedback, problem-solving, and continuous improvement can help strengthen workforce resilience while supporting retention and long-term program sustainability.

USE THIS TOOL

Concerned about workforce stress, burnout, or retention? Use the Workforce Wellness and Burnout Prevention Check-In.

> Tool 4.D

SECTION 4 KEY TAKEAWAYS & RESOURCE MAP

- **AFBSS depends on multidisciplinary, team-based care.** Staffing should be organized around the core functions of outreach, engagement, treatment, harm reduction, care coordination, and follow-up rather than specific disciplines alone.
- **Peer workers are essential members of the workforce.** Effective AFBSS programs fully integrate peers into outreach, engagement, care planning, shared caseload management, and team decision-making.
- **Staffing models should be adapted to local needs and resources.** Programs can scale workforce models based on population acuity, geography, available resources, and community context while preserving the core functions of AFBSS.
- **Caseloads should reflect acuity and field-based realities.** Workforce planning should account for outreach, travel, care coordination, documentation, and team consultation, with lower caseloads for individuals requiring more intensive support.
- **Shared responsibility and continuity of care are critical.** Team-based coverage models, structured workflows, and regular communication help ensure consistent engagement, coordinated care, and uninterrupted support.
- **Rural and frontier communities can successfully implement AFBSS through adaptation.** Strategies such as telehealth, regional partnerships, cross-training, and flexible staffing models can help address workforce and access challenges.
- **Training and supervision are ongoing workforce investments.** Staff require continuous skill development, field-based coaching, clinical supervision, and reflective supervision to support effective practice and maintain fidelity to the AFBSS model.

- **Workforce wellness and retention should be intentional priorities.** Organizations play a critical role in preventing burnout and supporting resilience through supportive supervision, manageable workloads, team-based support, professional growth opportunities, and a culture that promotes staff well-being.
- **Strong workforce systems improve both staff and client outcomes.** Investing in staffing, supervision, training, retention, and workforce wellness strengthens engagement, continuity of care, and long-term program sustainability.

IF YOU ARE READY TO…	GO TO…	
Assess workforce opportunities	> **Tool 4.A**	AFBSS Team Self-Assessment Tool
Evaluate training, supervision, and retention practices	> **Tool 4.B**	Training, Supervision, and Workforce Retention Checklist
Explore training resources for AFBSS teams	> **Tool 4.C**	Mobile Field-Based SUD Services Training Curriculum for a Multidisciplinary Team
Assess burnout risks and workforce wellness	> **Tool 4.D**	Workforce Wellness and Burnout Prevention Check-In

REFERENCES

Brown, M., Bender, K., Ferguson, K., Thompson, S. J., & Langenderfer, L. (2023). Reflective supervision training model: Impact on the supervisory working alliance. *Applied Learning in Social Work Education, 11*(1). https://alswe.simmons.edu/article/reflective-supervision-training-model-impact-on-the-supervisory-working-alliance/

California Health Care Foundation. (2026). *Street medicine: A critical pathway for behavioral health in California*. https://www.chcf.org/resource/street-medicine-pathway-behavioral-health-california/

Heller, S. S., & Gilkerson, L. (Eds.). (2009). *A practical guide to reflective supervision*. ZERO TO THREE.

Lynch, K. A., Harris, T., Jain, S. H., & Hochman, M. (2022). The case for mobile "street medicine" for patients experiencing homelessness. *Journal of General Internal Medicine, 37*(15), 3999–4001. https://doi.org/10.1007/s11606-022-07689-w

National Association of State Alcohol and Drug Abuse Directors. (2023, September 20). *Peer recovery support specialists: An overview of the evidence and key considerations for state substance use disorder systems* (Center of Excellence brief). https://nasadad.org/wp-content/uploads/2023/09/23.09.20_CoE-NASADAD-PRSS-Brief.pdf

SECTION 5:
PARTNERSHIPS, COLLABORATION, COMMUNITY INTEGRATION

PURPOSE

This section provides an overview of critical considerations for partnerships and collaboration in the context of Assertive Field-Based Substance Use Disorder Services (AFBSS). It begins by **defining the role of partnerships in AFBSS implementation, identifying key partners, and introducing foundational principles** that support effective collaboration.

The Behavioral Health Services Act (BHSA) requires counties to implement data-driven outreach, mobile field-based services, and open-access treatment approaches that increase access to Medications for Addiction Treatment (MAT). Achieving these goals requires coordination across multiple systems and sectors, including health and behavioral health care providers, housing agencies, community-based organizations, harm reduction programs, managed care plans, and other community partners.

While collaboration is not new to county behavioral health departments, AFBSS requires a level of coordination, engagement, and service integration that no single organization can provide alone. Strong partnerships help create seamless pathways to care, support continuity across settings, and connect individuals to the resources needed to promote stabilization, treatment engagement, and long-term recovery.

HOW TO USE THIS SECTION

This section highlights **strategies for developing and strengthening partnerships that support AFBSS implementation and service coordination**. As you review the content, consider:

- ☑ Which partnerships are most critical to achieving your implementation goals?
- ☑ Where do coordination challenges currently exist?
- ☑ How can collaboration improve access to care and continuity of services?

Throughout this section, you'll find partnership planning resources, collaboration strategies, and examples of cross-system coordination. These tools can help you **strengthen relationships and improve service integration**.

FOUNDATIONS OF EFFECTIVE PARTNERSHIPS

Implementing assertive field-based services for people with substance use disorder (SUD) requires a multidisciplinary, "whatever it takes" approach to meet individuals where they are, such as on the street, in encampments, in emergency departments, or transitioning from carceral environments back into the community.

Effective partnerships are built on mutual trust, shared accountability, strong communication, and complementary strengths of the organizations.

ASSESSING THE QUALITY OF YOUR PARTNERSHIPS

MUTUAL TRUST AND ACCOUNTABILITY Both partners operate with transparency, integrity, and a sense of shared responsibility for outcomes.	☑ Can sensitive information be shared openly, yet securely? ☑ Are partners following through on commitments? ☑ Is progress jointly tracked and reviewed?
STRONG COMMUNICATION Depends on candor, consistency, timeliness, and humility.	☑ Are important updates shared proactively (e.g. when issues arise)? ☑ Are challenges and setbacks discussed with intent to learn and improve? ☑ Can concerns be raised safely, respectfully, and without blame? ☑ Do both partners listen and respond to feedback?
COMPLEMENTARY STRENGTHS How complementary a partnership is may change over time.	☑ Are roles clear and aligned with each organization's strengths and capabilities? ☑ Does the partnership fill gaps that either organization could not address alone? ☑ Do partners value and recognize each other's contributions?

PARTNERSHIP STRUCTURE

Counties are encouraged to move toward formal partnerships over informal.

- **Informal partnerships** are built on mutual understanding and personal relationships, often without a written agreement. While they allow for flexibility and shared goals, they are less structured and more dependent on consistent goodwill, making them easier to dissolve. These arrangements resemble neighborly support—effective when trust is strong and founding relationships are in place but lacking formal accountability or guarantees.
- **Formal partnerships** are typically documented in a written contract or agreement, with both parties clearly defining roles, responsibilities (these may be both individual and shared), and objectives. While formal partnerships must also be built upon trust, the agreement is formalized and agreed upon.

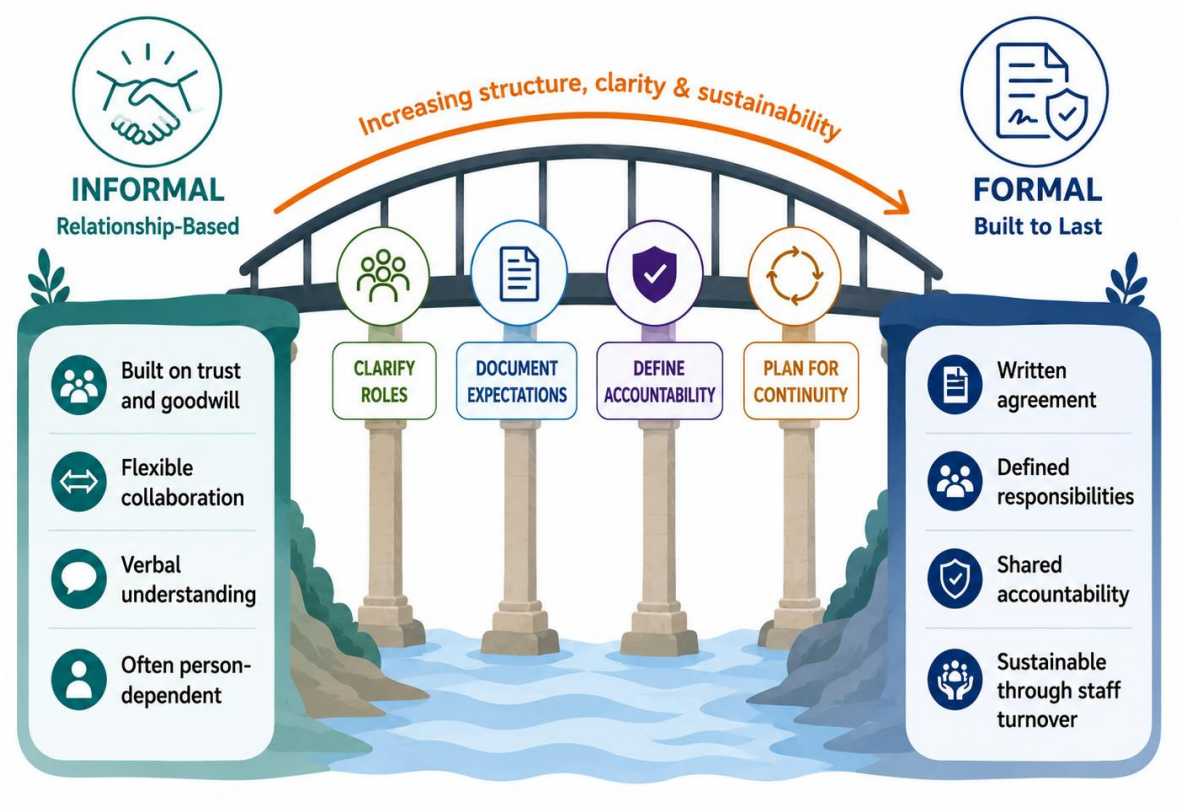
FIELD TIP

Build systems that outlast individual relationships.

Informal relationships can be a starting point. Formal agreements help make collaboration durable and outcomes stronger.

Formal relationships are especially important when involving:

- Service delivery
- Data sharing
- Financing
- Client transitions
- Ongoing coordination



BUILDING A COORDINATED PARTNERSHIP NETWORK

A systems approach is essential because no single organization can address the full range of health, behavioral health, housing, social, and recovery needs experienced by people with SUD.

A coordinated network of health and behavioral health care providers, harm reduction programs, social service agencies, peer supports, housing organizations, public safety and crisis partners, and other community organizations creates multiple pathways for engagement and reduces gaps in care. This approach supports continuity, improves communication across sectors, and recognizes that recovery and well-being are shaped not only by treatment, but also by social, economic, and community conditions.

REFLECT ON IT

Equity, person-centered approaches, and low-barrier access should guide how partners engage with one another and the communities they serve.

As you consider your network, ask:

Are partnership activities helping reduce barriers to care and engagement?

Does your partnership network reflect the cultural, linguistic, and community needs of the populations being served?

USE THIS TOOL

Want to assess the strength and effectiveness of an existing partnership? Use the Partnership Assessment Tool.

> Tool 5.A

COORDINATING WITH THE HOUSING AND HOMELESSNESS REPONSE ECOSYSTEM

A key component of this network is the housing and homelessness response ecosystem, including Continuums of Care, coordinated entry systems, homeless outreach teams, shelters, housing navigation programs, recuperative care programs, and permanent supportive housing providers. These partners may already be engaging many of the same individuals and communities prioritized for AFBSS.

Coordination with this ecosystem can help partners identify shared populations and service locations, build on existing relationships, clarify roles, align outreach and follow-up activities, and reduce unnecessary duplication. It can also help ensure that substance use treatment, behavioral health, medical care, and housing supports are delivered through a coordinated approach rather than through disconnected programs. Street medicine, harm reduction, and other community-based outreach teams should also be included when they serve shared populations or locations.

MAPPING THE AFBSS PARTNER NETWORK

Use this section to identify the organizations, providers, and community partners that collectively support engagement, treatment, recovery, and long-term stability for individuals with SUD. As you review the partner categories below, consider which organizations are currently part of your network, where gaps exist, and which relationships may need to be strengthened to improve coordination, access, and continuity of care.

USE THIS TOOL

Ready to identify and strengthen key AFBSS partnerships? Use the Partnership Network Mapping Worksheet.

> **Tool 5.B**



HOUSING & BASIC NEEDS PROVIDERS

These agencies help individuals obtain housing and meet basic needs. Close partnerships can facilitate placement for people experiencing homelessness, improve communication during transitions, and potentially expand access to available housing resources.

- **Homeless Services Agencies / Continuum of Care (CoC) Programs:** Regional housing and homelessness response systems that coordinate outreach, shelter, transitional housing, permanent supportive housing, and housing navigation.

- **Food Banks and Basic Needs Providers:** Community-based organizations that provide food, clothing, hygiene supplies, and other necessities that support immediate stabilization.

CLINICAL & HEALTH CARE PARTNERS



This category spans managed care plans, primary care, street medicine, harm reduction, pharmacy partners, and acute care settings. These partners can support referrals, treatment access, medication continuity, and transitions between levels of care. Safe and reliable handoffs are particularly important when an individual's needs change or they move between systems.

- **Medi-Cal Managed Care Plans (MCPs):** Coordinate Medi-Cal benefits, covered services, and connections across physical health, behavioral health, and social service systems.
- **Primary Care Providers and Federally Qualified Health Centers (FQHCs):** Provide integrated medical, behavioral health, and preventive services.
- **Emergency Departments and Hospitals:** Often serve as important access points for individuals experiencing overdose, substance-related medical complications, or behavioral health crises.
- **Syringe Services Programs and Harm Reduction Sites:** Provide low-barrier safer-use supplies, overdose prevention resources, education, and relationship-based engagement.
- **Pharmacy Partners:** Support medication access, medication management, and availability of MOUD and other treatment-related medications.

PUBLIC SAFETY & CRISIS PARTNERS



Law enforcement and crisis teams may serve as important access points for identifying and engaging individuals who need services. While crisis systems are not designed to provide ongoing treatment, they can facilitate referrals, support transitions to care, and help connect individuals with appropriate follow-up services.

COMMUNITY & PEER SUPPORT PARTNERS

Community-based and peer-led organizations can provide trusted, relationship-based support that strengthens engagement and helps individuals remain connected to services and recovery supports.



- **Peer Support Specialists:** Provide lived-experience support, engagement, and recovery-oriented assistance.
- **Community-Based Organizations:** Offer locally responsive and culturally relevant services, supports, and community connections.
- **Recovery Residences:** Provide structured, substance-free living environments and peer-centered recovery support outside formal treatment settings. Partnerships can help support continuity when individuals transition back into the community and reduce the risk of being lost to follow-up.
- **Recuperative Care Programs:** Provide short-term residential care for individuals experiencing homelessness who are recovering from an illness, injury, or hospitalization. Partnerships can support safe transitions from acute care, continuity of treatment and medications, and connection to housing and community-based services.

SPECIALIZED SERVICES & SOCIAL SUPPORTS

Recovery and stability may also depend on supports beyond healthcare and formal treatment. Partnerships with specialized service organizations can help address the broader conditions that influence long-term well-being.



- **Employment Services:** Provide vocational training, employment preparation, and job supports.
- **Family and Social Services:** Help address family needs, benefits, social supports, and other factors affecting stability.
- **Education Partners:** Connect individuals with educational, job-training, and skill-building opportunities

COORDINATION ACROSS THE NETWORK

Because AFBSS relies on a connected network of partners, it's important to be intentional about how these partners coordinate. Some partners provide services directly to individuals, while others support care through coordination, referrals, shared planning, and cross-system collaboration.

Ongoing information sharing across the network helps partners stay aligned, coordinate handoffs, respond to changing needs, and support continuity of care across settings. Not every partner will interact directly with every individual, but each may contribute information, resources, or expertise that strengthens the overall service response.

- **Direct Service Connections:** Partners engage with and provide services or supports directly to individuals.
- **Collaborative Partnerships:** Organizations coordinate activities, referrals, planning, and problem-solving across systems.
- **Information Sharing:** Partners exchange relevant information, as appropriate and permitted, to improve coordination, reduce gaps and duplication, and support continuity of care.

INFORMATION SHARING ACROSS PARTNERS

Effective AFBSS programs often rely on strong partnerships to support outreach, engagement, care coordination, and transitions between services. When sharing information across organizations, programs should establish appropriate consent, release-of-information procedures, and data-sharing agreements while ensuring compliance with HIPAA, FERPA, 42 CFR Part 2, and other applicable privacy requirements.

Build your processes and data-sharing agreements around the principles that information sharing should be purposeful, limited to the minimum necessary, and aligned with the individual's treatment goals, privacy preferences, and legal protections.

ADDITIONAL RESOURCES

Cross-Sector Partnership Assessment – A practical tool that helps partnerships assess their current stage of development, identify opportunities to strengthen collaboration, and access tailored feedback, planning guides, and discussion tools.

California Hub and Spoke System – Statewide model that expands MOUD access through partnerships between opioid treatment programs and office-based providers.

Collective Impact Forum – Tools and resources to support cross-sector collaboration, systems change, and community partnerships.

Partnerships for Action: California Health Care & Homelessness Learning Collaborative – Practical strategies for strengthening partnerships between healthcare and homelessness service providers.

SAMHSA Prevention Collaboration in Action Toolkit – Tools and worksheets for initiating, strengthening, and sustaining collaborative partnerships.

REGIONAL AND CROSS-COUNTY COLLABORATION

California counties vary considerably in size, geography, workforce capacity, provider availability, and service infrastructure. Through county interviews and regional partnership discussions, participants identified several implementation challenges that may be difficult for a

single county to address independently, including limited prescriber capacity, workforce shortages, long travel distances, transportation barriers, dispersed populations, and restricted access to specialized treatment services. Individuals who may benefit from AFBSS frequently seek services, receive care, or move across county boundaries, creating challenges that do not always align with local systems of care.

Regional collaboration may offer one strategy for addressing these challenges. Cross-county partnerships can help counties share scarce resources, reduce duplication of effort, build economies of scale, and expand access to specialized services that may be difficult to sustain within a single jurisdiction. Participants also described regional collaboration as an opportunity to strengthen peer learning, test new service models, and develop practical solutions that can be adapted across communities.

Regional approaches may be particularly helpful when counties experience:

- Limited prescriber or specialty-provider capacity
- Long travel distances to treatment services
- Workforce shortages
- Low service volume that makes a stand-alone service financially difficult to sustain
- Transportation barriers
- Communities that regularly access services across county lines
- A need for after-hours or specialized coverage that exceeds local resources

Two primary regional strategies may be worth exploring:

- A multi-county MAT access line.
- Shared medication unit and mobile narcotic treatment program capacity.

Multi-County MAT Access Line

A regional MAT access line can provide a low-barrier access point that helps individuals move from an initial request for help to prescriber connection, medication access, and linkage to ongoing treatment. Rather than creating separate hotlines in each county, participating counties may share staffing, clinical coverage, navigation capacity, technology, and evaluation resources. Field-based teams, hospitals, jails, emergency responders, and other referral partners can also use the hotline to support real-time warm handoffs.

ILLUSTRATIVE PILOT DESIGN ELEMENTS FOR A MULTI-COUNTY MAT HOTLINE

Pilot Design Element	Illustrative Approach
Structure and governance	Structure the pilot as a time-limited, multi-county demonstration, with one county or contracted organization serving as the operational lead. The lead entity could manage the hotline vendor or staffing contract, convene a small steering group, coordinate shared protocols, and prepare monthly performance summaries for all participating counties.
Operating window	Operate the hotline during a consistent four-hour weekday coverage window to test demand, staffing needs, and workflow feasibility. Counties could select a late-morning or afternoon window when prescribers, pharmacies, field teams, and transportation partners are most likely available, then adjust future hours based on call-volume.
Core hotline workflow	Use hotline staff trained to work with individuals experiencing withdrawal symptoms or other challenges to receive calls from individuals or referral partners, complete screening, connect callers to participating prescribers, confirm pharmacy access, arrange transportation or delivery support, and link patients to ongoing treatment providers. People delivering services in the field, hospital discharge planners, jail reentry staff, or EMS teams could call while with the patient so hotline staff can complete a warm handoff in real time.
Initial referral partners	Begin with a defined group of high-volume referral partners rather than immediately attempting broad inter-countywide implementation. Initial partners could include AFBSS or street medicine teams, county BH, FQHCs, EMS or fire departments, jails and reentry programs, probation, opioid treatment programs, withdrawal-management providers, a hospital or ED in each county, and community outreach organizations.
Shared measurement and evaluation	Use a shared workflow, common documentation expectations, and a small set of performance measures to assess demand, time to prescriber connection, medication access, warm handoffs, transportation needs, unsuccessful connections, and cost per successful engagement. Counties could track total calls, calls by county and hour, referral source, prescriber connection rate, medication connection rate, time to medication, transportation use, ongoing-provider connection, first-appointment attendance, repeat calls, and reasons connections failed.

Counties may wish to explore a regional access-line model when:

- Prescriber availability is limited
- Individuals have difficulty navigating treatment systems
- Transportation and referral barriers delay care
- Counties need a lower-cost method for expanding access
- Neighboring counties face similar access challenges

Shared Medication Unit and Mobile NTP Capacity

Regional medication-unit and mobile narcotic treatment program (MNTP) arrangements can help expand access to medications for opioid use disorder in communities located far from existing narcotic treatment programs. Rather than developing independent infrastructure in each county, neighboring counties may share medication-unit locations, mobile services, staffing resources, and operational costs. Because medication units and mobile narcotic treatment programs already operate within a well-established federal and state regulatory framework, counties can build on existing structures rather than creating entirely new models.

Consideration	Illustrative Approach
Assess regional need and travel burden	Map where current and prospective NTP patients live, travel distances to the nearest NTP, communities with little or no nearby medication access, areas with high treatment disengagement, and locations where transportation barriers are most significant. Use these data to identify where a fixed medication unit or mobile service could have the greatest impact.
Regulatory environment	Review applicable state and federal requirements for medication units, mobile units, and take-home medication. Because MUs and MNTPs operate within an existing, highly prescriptive federal and state regulatory framework, counties do not need to design these models from scratch; instead, they should use existing requirements as an implementation blueprint while identifying any barriers or needed flexibilities early so the regional model is workable and sustainable.
Regional service configuration	Consider several possible structures based on geography and demand. Multiple counties could jointly establish a medication unit near a shared geographic boundary and pair it with a mobile unit serving surrounding communities. Alternatively, counties could establish medication units within each county while sharing staffing and other resources.
Mobile unit routing	Design routes based on demonstrated need rather than county boundaries alone. Routes could prioritize communities with the

	longest travel times to an OTP, high rates of treatment disengagement, limited transportation options, or other significant access barriers. NTPs will need to consider dosing schedules that allow for sufficient take home bottles, so MNTPs can expand geographical access and not have to return to the same location daily.
Shared staffing model	Where feasible, consider having clinical staff travel between medication-unit locations rather than moving all infrastructure between sites. For example, dispensing nurses could serve multiple locations across participating counties, allowing counties to share specialized staff and potentially make more efficient use of billable clinical time.
Take-home medication protocols	Align clinical protocols for take-home medication, including criteria for increasing take-home bottles when clinically appropriate, to reduce unnecessary travel and make regional medication-unit models more workable for patients.
Cross-county governance and coordination	Establish clear agreements among participating counties and NTP partners regarding responsibilities, funding, staffing, use of shared infrastructure, data sharing, and coordination across county lines. A regional governance structure can help ensure that the model serves the broader service area rather than operating as several separate county programs.

Counties may wish to explore a shared medication-unit or mobile treatment model when:

- Significant travel distances limit access to treatment
- Existing NTP capacity does not adequately serve the region
- Multiple counties face similar medication-access challenges
- Geography makes county-specific infrastructure difficult to sustain
- Counties are interested in sharing specialized staffing and operational resources

USE THIS TOOL

Determining whether a regional approach is right for you? Use the Regional Partnership Readiness Assessment.

> **Tool 5.C**

ADDITIONAL RESOURCES

California DHCS Behavioral Health Information Notice (BHIN) No: 24-005 – This BHIN provides guidance for NTPs seeking to establish and operate mobile NTPs, including application requirements, approvals, licensing, security, and operational standards.

Creating a Mobile Narcotic Treatment Program (MNTP): Toolkit for Licensed Narcotic Treatment Programs (NTP) – This toolkit provides guidance for California opioid treatment programs on establishing mobile narcotic treatment programs (MNTPs), highlighting key considerations and implementation steps to expand access to care.

Mobile Narcotic Treatment Program Application – This application provides instructions and required documentation for NTPs seeking approval to operate mobile services in California.

Mobile Narcotic Treatment Programs Licensing Steps for Implementation Webinar – This webinar provides an overview of licensing and certification needs for MNTPs.

THE PARTNERSHIP LIFECYCLE: THE PROCESS OF PARTNERING

Partnerships are most effective when they are intentionally developed and maintained over time. For AFBSS programs, partnerships often support outreach, referrals, care coordination, housing access, medication access, crisis response, and recovery support. Establishing a structured process for developing and maintaining partnerships can help ensure that organizations move beyond information sharing and toward coordinated service delivery.

FIELD TIP

Build equity into partnerships.
At every stage of partnership development, consider whether the partnership expands access, reduces disparities, and strengthens engagement for populations that have historically experienced barriers.

Step 1: Initiate — **Who should we partner with and why?**

Identify a potential partner or opportunity to strengthen (or formalize) an existing relationship. Begin by exploring shared goals, unmet needs, and areas of mutual interest.

Step 2: Negotiate — **How will we work together?**

Clarify what each organization brings to the partnership, including resources, expertise, responsibilities, and expectations. Discuss how success will be measured and how challenges will be addressed.

Step 3: Formalize — **How will we operationalize the partnership?**

Document the partnership through an MOU, contract, referral agreement, linkage agreement, or other formal mechanism. Clearly define roles, responsibilities, communication pathways, and accountability structures..

Step 4: Implement & Monitor **How will it work on the ground? How will we monitor?**

Maintain the partnership through regular communication, joint problem-solving, performance review, and adaptation over time.

USE THIS TOOL

Building a new partnership or formalizing an existing one? Use the Multi-County Partnership Lifecycle Planning Worksheet. > **Tool 5.D**

SECTION 5 KEY TAKEAWAYS & RESOURCE MAP

- **Partnerships are essential to AFBSS implementation.** No single organization can meet the full range of needs that influence recovery, stability, and engagement.
- **Strong partnerships are built on trust, communication, accountability, and complementary strengths.** Regular assessment helps ensure partnerships remain effective over time.
- **A coordinated partner network improves access and continuity of care.** Housing, healthcare, peer support, crisis response, and social service partners each play an important role in supporting individuals with SUD.
- **Information sharing, referrals, and care coordination help reduce service gaps.** Effective networks create multiple pathways for engagement and recovery support.
- **Partnerships should be grounded in equity, cultural humility, trauma-informed care, person-centered approaches, and low-barrier access.**
- **Successful partnerships are intentionally developed and maintained.** The partnership life cycle includes initiation, negotiation, formalization, implementation, and ongoing monitoring.

IF YOU ARE READY TO...	GO TO...	
Assess the strength and effectiveness of an existing partnership	> **Tool 5.A**	Partnership Assessment Tool
Identify and strengthen key partners in your AFBSS network	> **Tool 5.B**	Partnership Network Mapping Worksheet
Consider a regional approach to partnering	> **Tool 5.C**	Regional Partnership Readiness Assessment

Build a new partnership or formalize an existing one > **Tool 5.D** Multi-County Partnership Lifecycle Planning Worksheet

REFERENCES

California Health Care Foundation. (2025). *Partnerships for Action: California health care & homelessness learning collaborative*. https://www.chcf.org/resource/partnerships-for-action-california-health-care-homelessness-learning-collaborative/

Center for Health Care Strategies. (n.d.). *Partnerships for Action: California health care & homelessness learning collaborative*. https://www.chcs.org/project/partnerships-for-action-california-health-care-homelessness-learning-collaborative/

Centers for Disease Control and Prevention. (2026). *Overdose Data to Action: Prevention strategies*. https://www.cdc.gov/overdose-prevention/php/od2a/prevention.html

Collective Impact Forum. (2016). *Cross-sector partnership assessment*. https://collectiveimpactforum.org/resource/cross-sector-partnership-assessment/

Lynch, K. A., Harris, T., Jain, S. H., & Hochman, M. (2022). *The case for mobile "street medicine" for patients experiencing homelessness*. **Journal of General Internal Medicine, 37**(15), 3999–4001. https://doi.org/10.1007/s11606-022-07689-w

Substance Abuse and Mental Health Services Administration. (2023). *Prevention collaboration in action toolkit*. https://www.samhsa.gov/technical-assistance/sptac/toolkit

SECTION 6:
CLINICAL PRACTICE AND SERVICE DELIVERY APPROACHES IN AFBSS

PURPOSE

This section provides practical guidance for delivering AFBSS in a person-centered, low-barrier, and integrated manner. It translates core concepts into operational practices that support engagement, treatment, care coordination, team-based service delivery, and continuous quality improvement.

The section helps counties, providers, and multidisciplinary teams:

- Explore how harm reduction, shared decision-making, low-barrier access, and whole-person care can strengthen engagement and reduce barriers to MAT.
- Consider how integrated care, multidisciplinary teamwork, and service coordination support continuity of care and long-term engagement.
- Evaluate program effectiveness using measures related to access, engagement, harm reduction, integrated care, equity, and Behavioral Health Transformation (BHT) priorities.

HOW TO USE THIS SECTION

This section provides practical guidance for **translating harm reduction principles into clinical practice, low-barrier engagement, integrated care, and team-based service delivery into day-to-day practice**. As you review the content, consider:

☑ What would help our team reduce barriers and engage individuals in care?
☑ How well do we coordinate care and measure meaningful outcomes?

Throughout this section, you'll find practical implementation strategies, assessment tools, planning resources, and quality improvement measures. These resources can help counties, providers, and community partners **strengthen service delivery, improve engagement, enhance care coordination, and support high-quality implementation of AFBSS**.

OPERATIONALIZING HARM REDUCTION IN AFBSS

Harm reduction incorporates a set of practical strategies designed to **reduce the potential harms** associated with substance use, most notably transmission of infectious diseases, overdose, and death.

Harm reduction is also an approach to service delivery that **rejects judgment of someone's behavior** and does not make the provision of services and resources contingent on drug use status.

In a policy context, the goal of harm reduction is to increase access to services and care for those who use drugs by destigmatizing drug use and addiction.

Harm reduction should inform how teams engage individuals, deliver services, make treatment decisions, and define success. A harm reduction approach recognizes that individuals are at different points in their recovery journey and their goals, priorities, and levels of readiness for change may evolve over time.

REFLECT ON IT

Harm reduction is an approach that incorporates public health strategies—including prevention, risk reduction, and health promotion—that help people who use drugs live healthy and purpose-filled lives.

How is harm reduction operationalized in your program?

How do your services promote safety, health, and engagement?

The National Harm Reduction Coalition has outlined eight principles of harm reduction. The next few subsections will focus on how to operationalize harm reduction within AFBSS.

USE THIS TOOL

Ready to assess how harm reduction principles are reflected in your program? Use Harm Reduction Practice Review.

> **Tool 6.A**

1

Reduce Harm, Increase Safety

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

2

Recognize the Continuum of Use

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

3	**Prioritize Quality of Life** Establishes quality of individual and community life and well-being as the criteria for successful interventions and policies, rather than focusing only on cessation of drug use.
4	**Refrain from Judgement and Coercion** Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live.
5	**Elevate Lived Experience** 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.
6	**Support Self-Determination and Empowerment** Affirms people who use drugs themselves as the primary agents of reducing the harms of their drug use, and seeks to empower them to share information and support each other.
7	**Address Social and Structural Factors** Recognizes that realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both vulnerability to and capacity for effectively dealing with drug-related harm.
8	**Acknowledge Risks While Promoting Safety** Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.



ADDITIONAL RESOURCES

American Medical Association (AMA) Harm Reduction Hub – Evidence-based guidance on harm reduction, overdose prevention, naloxone access, and person-centered care.

SBIRT"H": Incorporating Harm Reduction Strategies into the SBIRT Model - Resource from the American Society of Addiction Medicine that integrates harm reduction strategies into SBIRT to support practical, person-centered interventions.

Safer Injection Video for Physicians from Boston Medical Center – Educational video on safer injection practices to reduce overdose, infection, and other injection-related harms.

PRIORITIZING ENGAGENMENT OVER COMPLIANCE

Operationalizing harm reduction in AFBSS involves recognizing that engagement is often the first and most important intervention. Individuals may move through periods of engagement, disengagement, progress, recurrence of use, and re-engagement. Teams should anticipate these fluctuations and maintain connection whenever possible.

FIELD TIP

Relationship-building is often the intervention *before* the intervention.

Consistent presence, reliability, and responsiveness build trust and create opportunities for future engagement and treatment.

Operationally, this could look like:

- **Open Access:** Services are offered regardless of an individual's readiness to stop using substances.
- **No Discharge for Use:** Individuals are not discharged solely because of substance use.
- **Proactive Re-engagement:** Missed appointments trigger outreach and re-engagement efforts rather than punitive responses.
- **Reassess, Don't Discharge:** Continued substance use prompts reassessment of needs, service intensity, and treatment approaches rather than service termination.
- **Maintain Connection:** Teams maintain relationships through periods of instability whenever safe and appropriate.

The goal is to remain a consistent point of connection, even when individuals are not ready to engage in treatment or are experiencing setbacks.

START WITH WHAT MATTERS TO THE INDIVIDUAL

Because people often engage in services because of an immediate need rather than a desire to enter treatment, addressing those needs can create opportunities for trust, engagement, and future treatment conversations. As much as possible, build your systems and processes to understand what matters most to the individual and respond to those priorities whenever possible.

Operationally, this could look like:

- **Housing and Shelter Needs:** Assisting with housing, shelter, or encampment-related concerns.
- **Basic Needs Support:** Supporting access to food, water, hygiene resources, transportation, or identification documents.
- **Urgent Care Needs:** Addressing immediate medical or behavioral health concerns.
- **Benefits Navigation:** Helping individuals navigate benefits and social service systems.

- **Barrier Reduction:** Helping individuals respond to practical barriers that may prevent engagement in care.

PRIORITIZING SAFETY OVER ABSTINENCE

Harm reduction focuses first on preventing injury, illness, overdose, and death. While abstinence may be an important goal for some individuals, improving safety is an immediate priority for everyone.

Operationally, this could look like:

- **Routine Overdose Prevention:** Overdose prevention is incorporated into routine care and outreach.
- **Naloxone Access:** Naloxone education and distribution are integrated into service delivery.
- **Safer Use Education:** Teams discuss safer use practices (including safer injection) and overdose risk reduction strategies when clinically appropriate.
- **Whole-Person Safety:** Medical, behavioral health, and environmental safety concerns are addressed regardless of substance use status.
- **Prevent and Treat Infectious Disease**: This includes comprehensive HIV, hepatitis, and sexually transmitted infection (STI) testing and on-site treatment; vaccinations; and prescribing pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP).
- **Support Without Conditions:** Individuals receive support even if they continue to use substances.
- **Risk Reduction Focus:** Reducing harm is viewed as meaningful progress, regardless of abstinence.

ADDITIONAL RESOURCES

SAMHSA Overdose Preventions and Response Toolkit – Evidence-based guidance on overdose prevention, naloxone use, harm reduction, and overdose response for providers, individuals, families, and communities.

Implementation of an Integrated Infectious Disease and Substance Use Disorder Team for Injection Drug Use-Associated Infections – Describes an integrated infectious disease and SUD care model that improved coordination for people who inject drugs. Key implementation lessons include the importance of harm reduction, multidisciplinary care, strong communication, care coordination, and addressing housing, insurance, and other social needs alongside medical treatment.

REDUCING STIGMA THROUGH EVERY INTERACTION

Many individuals receiving AFBSS services have experienced stigma, discrimination, trauma, or negative interactions with healthcare and social service systems. These experiences can create barriers to engagement and trust.

Operationally, this could look like:

- **Person-Centered Language:** Using respectful, person-centered language.
- **Nonjudgmental Communication:** Avoiding judgmental labels or assumptions.
- **Chronic Disease Approach:** Treating SUD as a chronic health condition.
- **Context Awareness:** Recognizing the impact of trauma, poverty, homelessness, and systemic inequities.
- **Welcoming Environments:** Creating environments where individuals feel welcomed, valued, and respected.

MEASURING SUCCESS BEYOND ABSTINENCE

An important component of operationalizing harm reduction in AFBSS is how success is defined using a broader and more person-centered view of progress than simply abstinence.

Success may include:

- **Service Engagement:** Increased engagement with services.
- **Overdose Risk Reduction:** Reduced overdose risk.
- **Safer Use Practices:** Increased use of safer-use practices.
- **Treatment Engagement:** Initiation or continuation of medications for addiction treatment.
- **Health Improvement:** Improved physical or behavioral health.
- **Housing Stability:** Increased housing stability.
- **Reduced Crisis Utilization:** Reduced crisis utilization.
- **Social Reconnection:** Reconnection with family, community, or support systems.
- **Goal Achievement:** Progress toward self-identified goals.
- **Sustained Connection:** Continued engagement despite ongoing substance use.

FIELD TIP

Recovery is often non-linear. Small improvements in safety, stability, health, and engagement can represent important milestones and should be recognized as meaningful progress.

See the section on Quality Improvement and Measuring Success for ideas on how to measure success of harm reduction strategies.

LOW-BARRIER SERVICE DELIVERY

AFBSS is designed to reduce barriers that prevent individuals from accessing and remaining engaged in MAT.

Traditional treatment requirements such as lengthy intake processes, mandatory counseling, multiple appointments before treatment initiation, or discharge for ongoing substance use can unintentionally create barriers to care.

AFBSS uses low-barrier approaches that emphasize rapid access to MAT, flexibility, engagement, and continued connection to services.

CONSIDER THIS

Programs should monitor whether low-barrier approaches are translating into improved access.

Instead of: Assuming that offering low-barrier services automatically improves access and engagement.

Try this: Track whether same-day access, rapid treatment initiation, and flexible engagement strategies are helping individuals connect to care.

USE THIS TOOL

Ready to strengthen low-barrier access to care? Review the SAMHSA Advisory: Low-Barrier Models of Care for Substance Use Disorders.

REMOVING LOGISTICAL & ADMINISTRATIVE BARRIERS

Low-barrier care removes unnecessary requirements that delay or prevent access to treatment. The goal is to make services easier to access rather than expecting individuals to adapt to rigid program structures or administrative requirements.

Operationally, this could look like:

- **Bringing Care to Them:** Services are delivered in community settings where people live and spend time.
- **Rapid Access:** Same-day or rapid access to assessment, treatment, and medications is offered whenever possible.
- **No Counseling Requirement:** Counseling and recovery supports are available but are not required to access medications or other services.
- **Reduced Barriers:** Treatment is not delayed by unnecessary paperwork, appointments, or administrative requirements.
- **Flexible Service Delivery:** Service delivery approaches are responsive to individual circumstances and needs.

RAPID ACCESS TO MEDICATION

Consider ways in which your program can provide rapid access to medications for addiction treatment while minimizing barriers that delay care.

Operationally, this could look like:

- **Same-Day Treatment:** Initiating medications as quickly as clinically appropriate.
- **Medication Before Counseling:** Encouraging counseling but not making it a perquisite for treatment.
- **Continue Treatment:** Ongoing substance use prompts reassessment and support rather than discontinuation of treatment.
- **Multiple Recovery Goals:** Making medications available to individuals pursuing abstinence, reduced use, safer use, or overdose prevention goals.
- **Treatment on Demand:** Minimizing delays between an individual's decision to seek treatment and treatment initiation.

OPEN-ACCESS SERVICES

Consider ways in which your program can create opportunities for engagement whenever individuals are ready to access care. Rather than relying only on scheduled appointments, AFBSS teams should look for ways to provide flexible pathways to assessment, treatment initiation, and ongoing support.

Operationally, this could look like:

- **Flexible Scheduling:** Offering walk-in, outreach, telehealth, and scheduled appointment options.
- **Field-Based Access:** Delivering services in community settings whenever possible.
- **Same-Day Availability:** Prioritizing rapid treatment initiation and medication access.
- **Re-Engagement Focus:** Missed appointments resulting in outreach rather than punitive responses.
- **Community-Informed Design:** Adapting service locations, hours, and delivery models to community needs.

FLEXIBLE AND INDIVIDUALIZED SERVICE DELIVERY

Meeting people where they are requires more than providing services in community settings. It requires adapting services to the individual's circumstances, strengths, culture, language, preferences, and readiness for change.

Operationally, this means:

- **Acuity-Based Outreach:** Outreach intensity is adjusted based on acuity and need.
- **Communication Preferences:** Services are tailored to an individual's communication preferences and access challenges.
- **Culturally Responsive Engagement:** Cultural and linguistic needs are incorporated into engagement strategies.
- **Barrier Adaptation:** Teams adapt services to accommodate housing instability, transportation barriers, and limited access to communication devices.
- **Dynamic Care Planning:** Care plans are regularly adjusted as needs and circumstances change.

USE THIS TOOL

Ready to identify an action plan to reduce service delivery barriers? Use the Low-Barrier Service Delivery Self-Assessment.

> Tool 6.B

INFORMED CONSENT IN FIELD-BASED SETTINGS

Informed consent is an essential part of person-centered, field-based care. It is both a point-in-time activity and an ongoing communication process. Informed consent means the individual receives information about a proposed service or treatment, has an opportunity to ask questions, demonstrates understanding, and voluntarily decides whether to accept or decline care. Informed consent requires more than obtaining a signature or documenting consent in the health record. The treating professional must provide enough information to support an informed decision, confirm understanding, and document the discussion. These same principles apply in field-based and facility-based settings.



What is informed consent?

"Informed consent" refers to legal and ethical requirements for health care providers to obtain an individual's agreement to treatment recommendations after they are provided with adequate information about the nature, benefits, risks, and alternatives of the proposed treatment. Informed consent also requires that the individual convey that they understand this information and that they are making informed and knowledgeable decisions about their health care.

Individuals should always have the opportunity to ask questions and may choose to consult with peers, friends, family, or other trusted supports prior to providing consent.



Does a person have the right to decline treatment for substance use services, and what should field-based providers document when a person declines treatment?

Yes. Adult individuals in the field, just like any other patient, have the right to make their own decisions related to their healthcare, including declining SUD treatment. Documentation should include:

- Treatment that was offered,
- Alternative options were discussed,
- The individual's decision to decline,
- The individual's explanation, if any, for declining, and
- Plans for future engagement when appropriate.



What are the minimum consent requirements for field-based SUD treatment?

Programs should ensure consent processes align with clinical standards, regulatory requirements, and county-specific policies while avoiding unnecessary barriers to engagement (e.g., not requiring that all documents be completed/signed at first visit). The minimum requirements should include a standardized consent form to be signed at the initiation of treatment, plus documentation of the informed consent discussion related to specific SUD treatments.

SUPPORTING MEANINGFUL CONSENT IN THE FIELD

CONSENT TO TREATMENT IN THE FIELD: WORKFLOW

Informed consent, including in field-based settings (e.g., street medicine, mobile crisis), requires more than a signature or documentation in the health record. The treating provider must provide sufficient information for the patient to make an informed decision, confirm the

patient understands the risks and benefits of the proposed treatment, and document the discussion.

Under federal and California law, a provider is obligated to obtain informed consent before providing medical treatment, including SUD treatment. Informed consent means the provider shares information that a reasonable person would consider in deciding whether to accept or decline treatment, including expected risks and benefits, alternatives, and the individual's right to decline. Providers should seek guidance from their legal counsel as appropriate.

Step 1: Ensure Effective Communication



Be prepared with the necessary tools to ensure the patient can provide informed consent.

Best Practices

- Use qualified medical interpreters.
- Use bilingual providers when appropriate.
- Identify a substitute decision-maker in case of emergency.
- Provide accommodations for cognitive, developmental, hearing, or visual accessibility needs.

Use a Trauma-Informed Communication

- **Physical and Emotional Safety**: Approach individuals slowly, ask permission before entering personal spaces, and be mindful of body language.
- **Choice and Control**: Allow the patient to direct the pace and scope of medical care; recognize their absolute right to decline treatment.
- **Transparency and Trust**: Explain every action, tool, and diagnostic step clearly before performing it.
- **Nonjudgmental Engagement**: Meet basic needs (such as wound care or harm reduction supplies) without demanding abstinence or immediate behavioral changes.
- **Involve Peers**: Integrate community health workers and peers with lived experience to build immediate rapport.
- **Consistent Presence**: Return to the same locations routinely; treat care as an ongoing relationship rather than a one-time transactional visit.

Step 2: Obtain Informed Consent for Treatment & Assess Decision-Making Capacity



Before providing any kind of medical treatment, providers are legally and ethically obligated to obtain and document informed consent. Patients should have the opportunity to ask questions and may choose to consult with trusted supports prior to providing informed consent.

Treatment in the Field May Include:

- Behavioral health screening.
- Substance use assessment.
- Medication.
- Vital signs.
- Wound care.
- Laboratory collection.

Consent May Be:

- Paper or electronic signature.
- Documented in Electronic Health Record/chart by provider.

Discuss with the Individual:

- The patient's condition or reason for evaluation.
- What services will be provided.
- Name of the treatment/medication.
- Expected benefits.
- Reasonably foreseeable risks.
- Common side effects.
- Reasonable alternatives.
- Possible consequences of not taking medication.
- The patient's right to decline or stop treatment at any time.

Assess Decision-Making Capacity

There may be instances where the provider determines a need to assess the patient's capacity to make healthcare decisions, recognizing that intoxication, severe withdrawal, delirium, cognitive limitations, or acute psychiatric symptoms may temporarily impair capacity. In these instances, the provider will assess whether the patient is able to:

- Communicate a choice.
- Understand their medical condition.

Step 3 **If the Individual Declines the Medication**



Continue other appropriate services when possible.

Explain potential consequences.

Encourage follow-up.

Discuss alternative options.

Document the declination of treatment.

Step 4 **Document the Interaction**



Document:

- Patient's decision to take or decline medication.
- As appropriate, provider's assessment of patient's capacity to consent/decline treatment.
- Information discussed (risks, benefits, alternatives).

- Note patient's concerns, questions and comments, and provider's responses.
- Interpreter use (if applicable).
- Follow-up recommendations.
- Patient signature.

When written or electronic signatures are unavailable, document verbal consent in the Electronic Health Record.

SOURCES: California's general informed consent doctrine for medical treatment is grounded in *Cobbs v. Grant*, 8 Cal. 3d 229 (1972), and subsequent California case law, which require providers to disclose information material to a patient's decision to accept or decline treatment, including material risks, benefits, and reasonable alternatives. California statutes and regulations impose consent-related requirements in behavioral health and other specific contexts, but California does not provide a standalone statutory definition of informed consent specifically for SUD treatment.

USE THIS TOOL

Ready to have and document conversations around consent in the field? Use the checklist and charting guidance in Consent to Treatment in the Field – Tools.

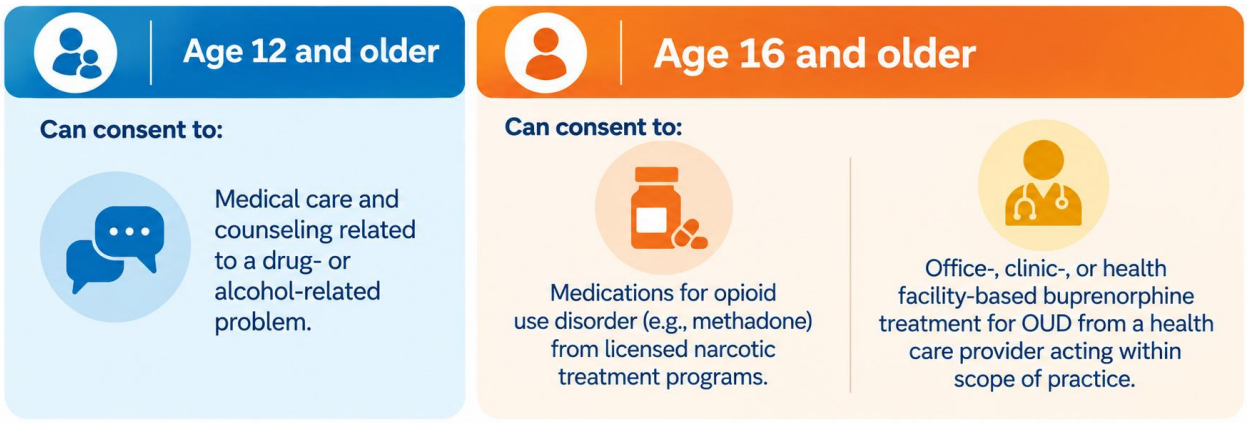
> **Tool 6.C**

CONSENT CONSIDERATIONS FOR YOUTH

Consent requirements for youth vary based on the individual's age, the service being delivered, the treatment setting, the medication involved, and applicable state and federal requirements. Programs serving minors should maintain current procedures addressing consent, confidentiality, parent or guardian involvement, documentation, and circumstances in which additional legal or clinical consultation is needed.

Unemancipated youth cannot decline SUD treatment when a parent or guardian recommends and consents for the treatment.

Please understand that this information is intended to provide general information and considerations regarding minor consent. It does not constitute legal advice and should not be relied upon as a legal determination regarding any specific individual, case, or circumstance. Organizations should consult qualified legal counsel when applying federal, state, or local law to particular facts.



ADDITIONAL RESOURCES

The **National Center for Youth Law (NCYL) Minor Consent and Confidentiality Resources** provide practical guidance on California laws related to youth consent, confidentiality, and access to substance use disorder treatment and health services.

Resources include:

- Frequently Asked Questions About Minor Consent for SUD Services in California – Answers common questions about youth access to SUD treatment.
- California Minor Consent and Confidentiality Laws: Quick Reference Chart – Quick reference guide to California consent and confidentiality laws.
- Minor Consent and Confidentiality: A Compendium of State and Federal Laws (California) – Comprehensive overview of California minor consent and confidentiality requirements.
- California Family Code Section 6929 – The code allows minors 12 and older to independently consent to their own outpatient SUD diagnosis, counseling, and medical care without parental permission.

USING MOTVIATIONAL INTERVIEWING TO SUPPORT SHARED DECISIONMAKING

Individuals are more likely to remain engaged when they have an active role in decisions about their care. AFBSS relies on **relationship-based engagement strategies** that help teams build trust, support self-determination, and strengthen motivation for change over time.

Operationally, this means:

- **Goal-Driven Care:** Teams begin by understanding the individual's goals, priorities, strengths, and concerns.
- **Informed Choice:** Treatment options are presented clearly, including potential benefits and risks.
- **Shared Decision-Making:** Individuals are supported in making informed decisions about their care.
- **Individualized Care Planning:** Care plans reflect the individual's goals whenever possible.
- **Collaborative Partnership:** Teams work collaboratively with the individual rather than directing care without their input.

CONSIDER THIS

Responding to someone's priorities and goals creates opportunities for deeper engagement and future treatment conversations.

Instead of: Beginning every interaction by focusing on treatment goals.

Try this: Start by building trust and addressing immediate needs when possible.

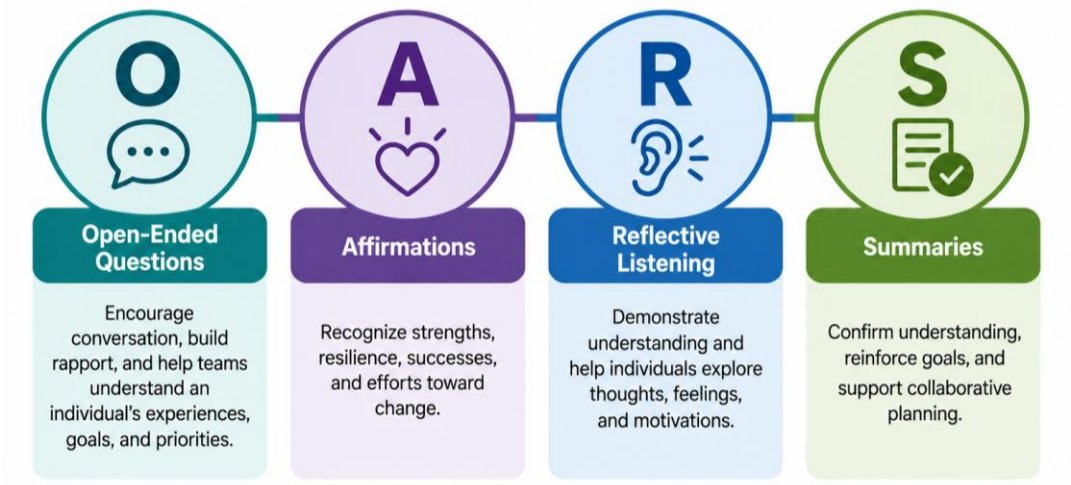
CORE PRINCIPLES OF MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is a counseling approach designed to help individuals resolve ambivalence about behavioral change, including their alcohol and/or drug use, and supports efforts to change it. MI is often delivered as a brief intervention based on client-centered principles.

- **Partnership**: Team members bring expertise in change and treatment; individuals bring expertise in their own lives and experiences.
- **Evocation**: Rather than telling people why they should change, teams help individuals identify their own priorities, strengths, and reasons for change.
- **Acceptance**: Teams maintain a nonjudgmental stance, express empathy, and respect an individual's right to make informed choices.
- **Compassion**: Engagement is grounded in genuine concern for the individual's well-being and goals.

USING OARS TO SUPPORT ENGAGEMENT

The **OARS model** provides practical communication skills that support effective outreach, engagement, and care planning.



ADDITIONAL RESOURCES

The Agency for Healthcare Research and Quality compiled the OARS Model: Essential Communication Skills job aid to build rapport with patients using the OARS framework.

CONTINGENCY MANAGEMENT (CM)

Contingency management (CM) is an evidence-based treatment that provides motivational incentives to reinforce positive behavior change, including treating individuals living with stimulant use disorder and supporting their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests that are negative for stimulants. CM has an especially strong evidence base for stimulant use disorder; it has also been used across substance use disorder treatment to support engagement, medication adherence, abstinence or reduced substance use, and other positive health behaviors.

FIELD TIP

Reward progress without making support conditional.

Contingency Management incentives are connected to identified behavior, but access to treatment, harm reduction, outreach, medications, and other needed services should not depend on whether the individual earns the incentive. If a target is not met, use the opportunity to reassess barriers, adjust the plan, and maintain engagement.

CM is grounded in positive reinforcement. The individual and care team identify a behavior that is meaningful, achievable, and objectively verifiable. When the behavior occurs, the incentive is provided promptly and consistently. CM should be delivered

transparently and collaboratively, without shame, punishment, or loss of access to other services when the target behavior is not achieved.

BEHAVIORS THAT MAY BE REINFORCED

Programs should select behaviors that are **clinically meaningful, achievable, clearly defined, and verifiable**. Incentives should not be used to pressure individuals into treatment decisions or reward compliance with goals selected solely by the program. Depending on the individual's goals, clinical needs, and program design, CM may reinforce:

- **Treatment engagement:** Attending counseling, medical, medication-management, or care coordination visits.
- **Medication adherence:** Taking prescribed medications or completing medication follow-up activities.
- **Substance-related goals:** Providing substance-negative test results or demonstrating progress toward an individually defined reduction or abstinence goal.
- **Recovery participation:** Engaging in peer support, recovery activities, or other agreed-upon supports.
- **Health and wellness activities:** Completing medical appointments, infectious disease screening or treatment, preventive care, or other health-related activities.
- **Care-plan goals:** Completing specific, achievable steps that support stability, health, or continued engagement in care.

CORE IMPLEMENTATION PRINCIPLES

Immediate reinforcement, adequate incentive value, and frequent opportunities to achieve the target behavior are important elements of effective CM. Programs should implement CM using an established protocol and ensure staff are trained in the intervention rather than using informal or inconsistently administered rewards. Effective CM programs generally:



ADDITIONAL RESOURCES

The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder identifies contingency management (CM) as the current standard of care for stimulant use disorder and provides practical guidance on implementing CM and other evidence-based behavioral interventions.

Using SAMHSA Funds to Implement Evidence-Based Contingency Management Services outlines current federal guidance on contingency management, including incentive structures, program safeguards, and examples of treatment, recovery, and medication-adherence behaviors that may be reinforced through CM.

The UCLA Integrated Substance Use and Addiction Programs (ISAP) offers trainings for the Recovery Incentives Program: California's Contingency Management Benefit.

APPLYING CM IN AFBSS

AFBSS programs may need to adapt CM delivery to field-based and low-barrier settings. Implementation planning should address how:

- Participants will have reliable and equitable opportunities to earn incentives.
- Target behaviors will be verified in community settings.
- Incentives will be stored, transported, distributed, and documented.
- Participants without phones, transportation, stable housing, or regular facility access will participate.
- The program will respond when field conditions interrupt scheduled contacts or testing.
- CM will remain voluntary and aligned with harm reduction and shared decision-making.
- Peers and other team members will support explanation, engagement, follow-up, and reinforcement.
- Funding, billing, program-integrity, and applicable legal requirements will be reviewed before implementation.

COMPREHENSIVE, INTEGRATED, WHOLE-PERSON CARE

People with SUD often experience overlapping mental health, medical, housing, and social needs. Traditional systems frequently address these needs separately, requiring individuals to navigate multiple programs, providers, and referral pathways. Consider ways in which your AFBSS program can take a different approach by delivering coordinated, whole-person care that addresses multiple needs simultaneously rather than sequentially.

REFLECT ON IT

How do you address multiple needs at the same time?

Would individuals describe your services as "one person, one care plan"? Why or why not?

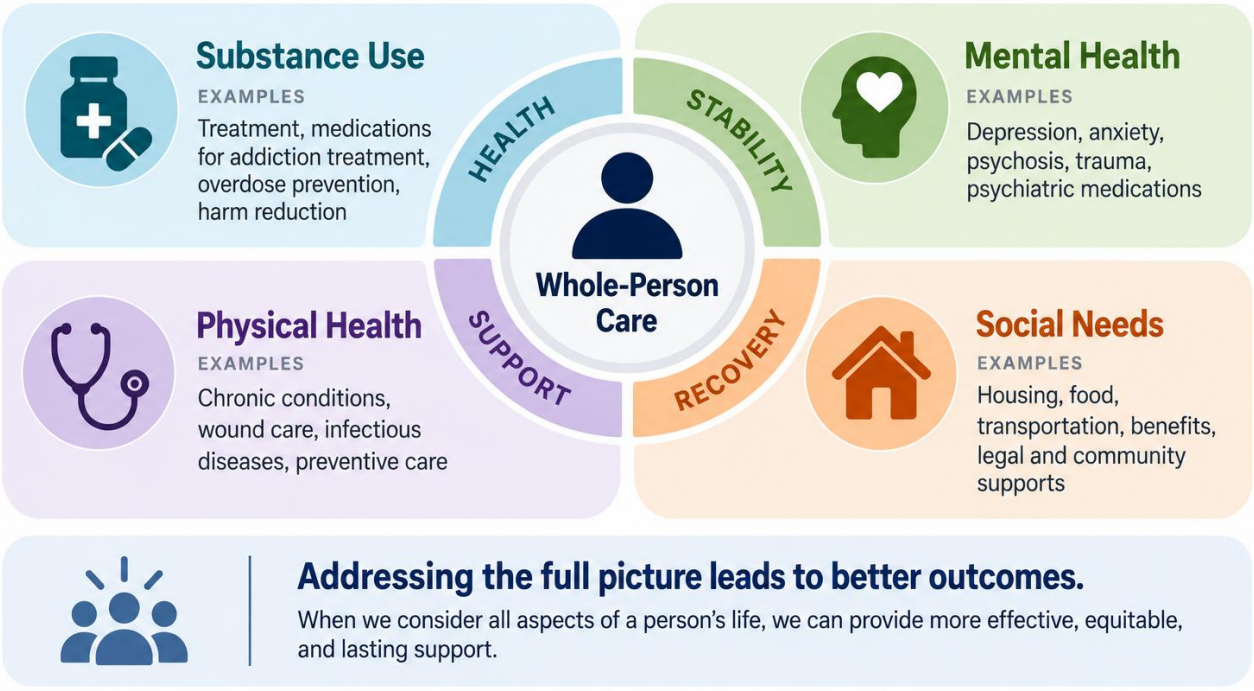
USE THIS TOOL

Ready to explore whole-person approaches to care for individuals experiencing homelessness and opioid use disorder? See the Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder Toolkits (Parts One and Two).

WHAT MAKES CARE "COMPREHENSIVE" IN AFBSS?

Rather than treating substance use disorder in isolation, AFBSS teams should assess and respond to the **full range of factors affecting health, stability, and recovery**.

Effective care addresses these needs together whenever possible rather than delaying one service until another issue has been resolved.



INTEGRATING CARE FOR CO-OCCURRING NEEDS

People receiving AFBSS services often experience substance use, mental health, physical health, housing, and social service needs at the same time. These needs are interconnected and should be addressed concurrently whenever possible. Rather than referring individuals to multiple disconnected systems, AFBSS teams should work to coordinate care across service domains and help ensure needs are addressed through a unified, whole-person approach.

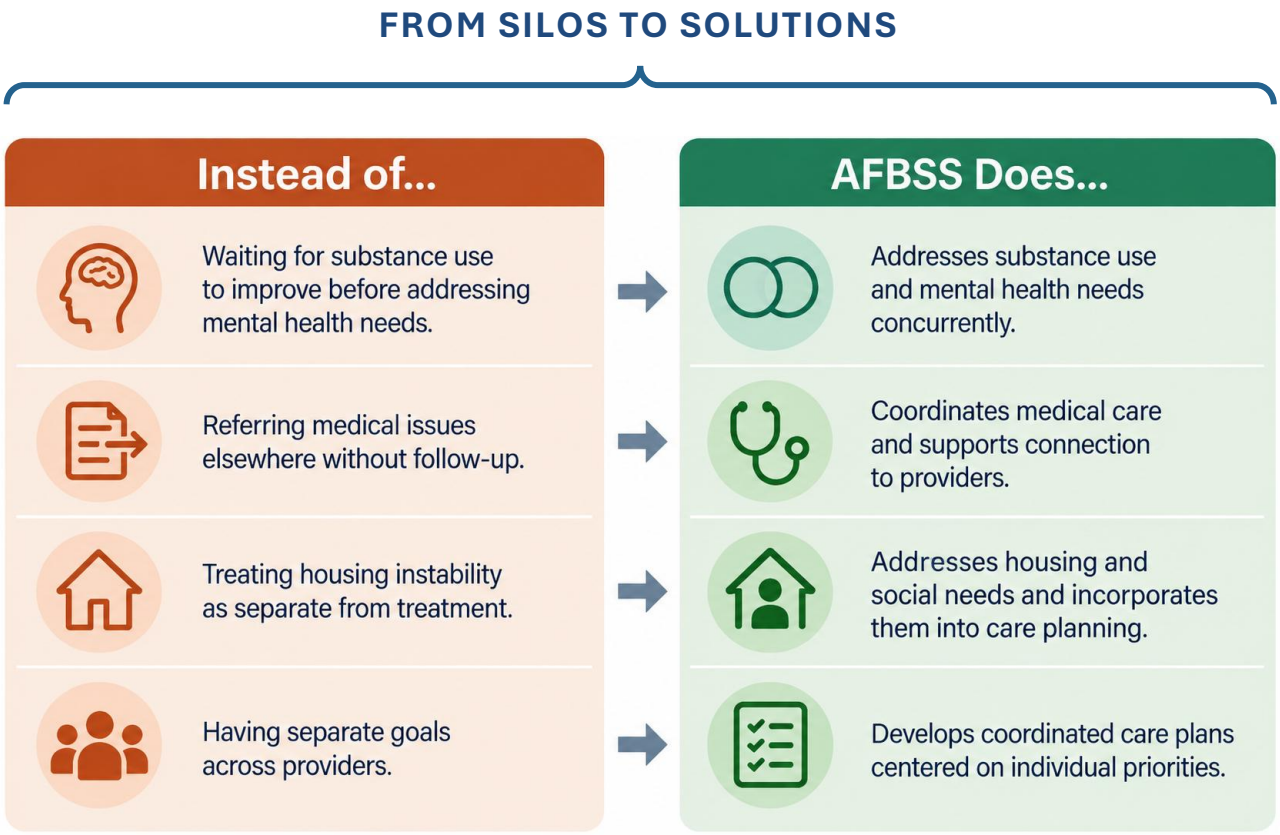
FIELD TIP

One Person, One Care Plan

Whenever possible, organize services around a **single care plan** that reflects the individual's goals. Individuals may work with multiple providers, but they should experience care as one coordinated system, not multiple disconnected services.

One hallmark of integrated care is that individuals experience services as a coordinated system rather than a collection of separate programs or providers. The goal is to create **one person, one care plan**, with services organized around the individual's goals, priorities, and needs. Achieving this level of coordination requires timely and

appropriate sharing of client information across the providers and systems involved in an individual's care, consistent with applicable privacy and confidentiality requirements. Programs should establish processes that support necessary information sharing while protecting client privacy. See Information Sharing Across Partners for additional information.



Effective integrated care planning includes:

- **Shared Goals:** Team members work toward common objectives aligned with the individual's priorities.
- **Cross-Disciplinary Coordination:** Medical, behavioral health, substance use, and social service providers collaborate to deliver care.
- **Defined Team Roles:** Team members understand their responsibilities while maintaining flexibility to respond to changing needs.
- **Ongoing Reassessment:** Care plans are reviewed and updated as circumstances, goals, and acuity change.
- **Person-Centered Planning:** Services and interventions reflect the individual's strengths, preferences, and self-identified goals.

The objective is a single, coordinated approach to care that reduces fragmentation, improves communication, and helps individuals receive the services they need in a way that feels connected and responsive.

Integrating Physical Health Into AFBSS

Many individuals receiving AFBSS services have significant unmet medical needs that contribute to poor health outcomes and interfere with recovery.

Physical health integration may include:

- Primary care screening and treatment.
- Wound care and monitoring.
- Infectious disease testing and treatment.
- Medication management.
- Preventive health services and coordination with specialty providers.

When direct medical services are unavailable, programs should establish strong partnerships to facilitate timely access to care and ensure follow-through.

Integrating Mental Health Into AFBSS

Mental health conditions frequently co-occur with substance use disorders and should be addressed as part of routine service delivery.

Effective integration of mental health needs includes:

- Mental health screening and assessment.
- Ongoing symptom monitoring.
- Access to psychiatric treatment and medications.
- Coordination between SUD and mental health providers.
- Trauma-informed approaches to care.

CARE COORDINATION AS A CORE SERVICE

Many individuals served through AFBSS receive services from multiple providers, systems, and community organizations. Care coordination helps ensure these services work together to support treatment goals and continuity of care. Care coordination may include:

- **Connecting individuals** to medical, behavioral health, housing, and social service providers.
- **Scheduling** and coordinating appointments.
- **Facilitating referrals** and ensuring follow-through.
- **Supporting transitions** between levels of care.
- **Communicating** with providers, family members, and community partners when appropriate (see Information Sharing Across Partners for more information).
- **Addressing practical barriers** that interfere with engagement.

FIELD TIP

Build in information-sharing agreements into your partnerships.

Effective care coordination depends on timely communication and appropriate information sharing among providers, partners, and systems while maintaining compliance with applicable confidentiality and privacy requirements.

ADDITIONAL RESOURCES

USC Street Medicine Resource Center – This resource center provides guidance and practical tools to help street medicine programs develop, launch, and sustain effective services. It covers key areas such as funding, field safety, operations, supplies, partnerships, and emerging best practices to support communities serving people outside traditional healthcare settings.

TEAM-BASED CARE IN AFBSS

A team-based approach to care delivery for AFBSS team is important because it allows all members to **contribute at the top of their capacity and training**.

The team-based approach includes the client and community collaborators and requires that they have a voice and actively participate in client care.

Team-based care is more than just having multiple contributors to a care team. Unlike traditional models that assign primary responsibility to an individual provider, AFBSS relies on **teams that work collaboratively to support engagement, treatment, care coordination, and long-term stabilization**.

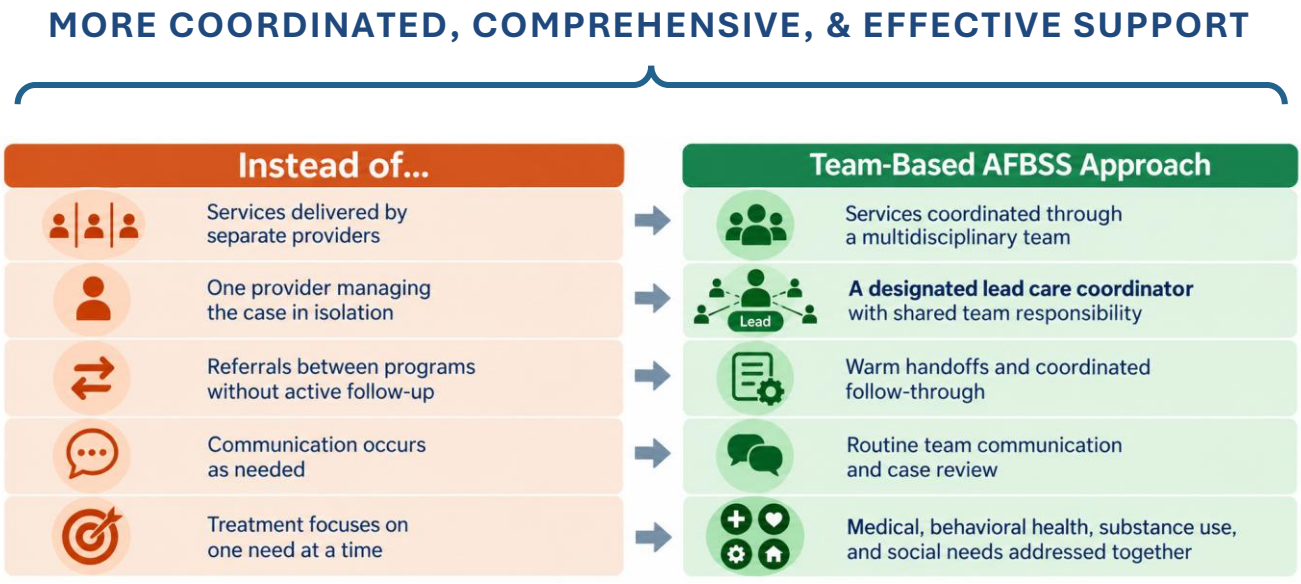
It's a re-orientation that allows programs to coordinate services, share responsibility for outcomes, maintain continuity during crises, and deliver more integrated and responsive care in community settings.

REFLECT ON IT

- To what extent do individuals experience their care team as coordinated, responsive, and connected?
- In what ways do team members contribute their unique expertise to support shared goals?
- How does your team maintain continuity of care when needs, circumstances, or staffing change?
- What strengths of your current team-based approach should be preserved and expanded?

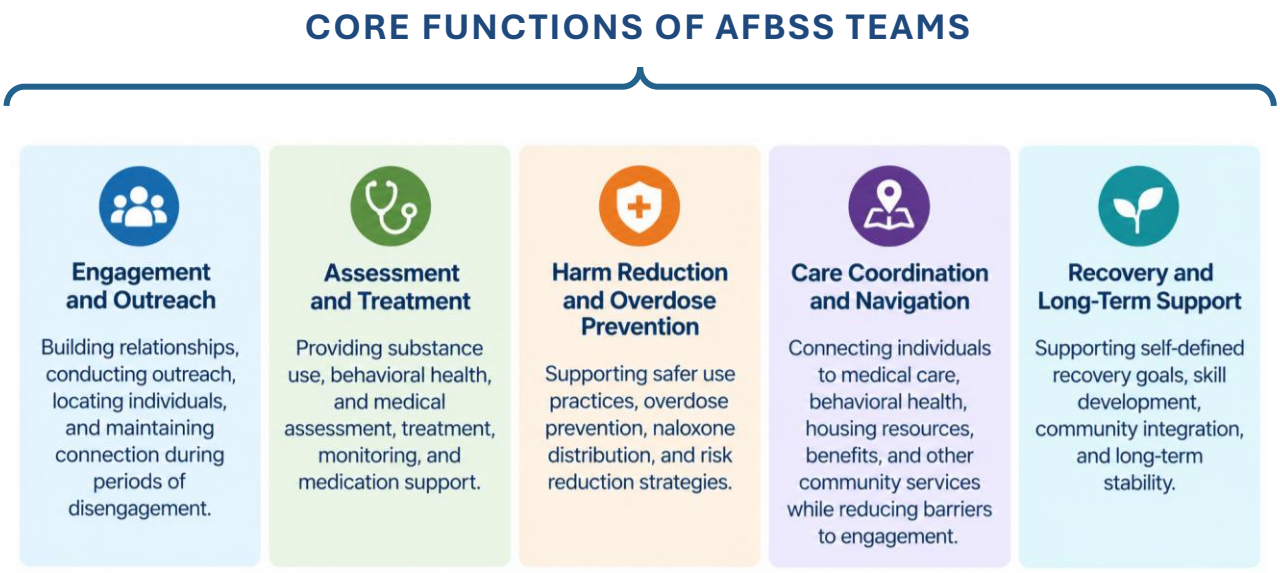
WHAT MAKES TEAM-BASED CARE DIFFERENT?

In AFBSS, the team functions as a coordinated unit rather than a collection of individual providers working in parallel.



CORE TEAM FUNCTIONS

The hallmark of an AFBSS team is not a specific staffing pattern, but rather a multidisciplinary team capable of delivering integrated medical, behavioral health, harm reduction, and social support services in community settings where people live and spend time. Regardless of staffing model, successful AFBSS teams perform a common set of functions.



Regardless of team composition, programs should ensure these core functions are consistently available and coordinated. Also, remember to include your partnerships in these service delivery conversations.

For more information on staffing this multidisciplinary team), see Section 4: Staffing, Workforce Capacity, And Training. For more information on partnerships, see Section 5: Partnerships, Collaboration, Community Integration.

SHARED ACCOUNTABILITY

One of the defining characteristics of team-based care is shared accountability. While team **members may have specific responsibilities, the team collectively shares responsibility** for engagement, care planning, continuity of care, and treatment outcomes.

Shared accountability includes:

- Maintaining engagement with individuals who may be difficult to reach.
- Supporting continuity during staff absences or transitions.

- Collaboratively responding to crises and emerging needs.
- Monitoring progress toward treatment and recovery goals.
- Sharing responsibility for care planning and follow-up.

Shared accountability should not mean unclear accountability. When responsibility is shared across a team, it can be easy to assume someone else is handling a task, referral, follow-up, or outreach need. To avoid gaps in care, teams should leave every huddle, case conference, or care planning discussion with clear agreement on:

- What specific action will be taken.
- Who is responsible for the next action.
- Who else needs to be involved or informed.
- When follow-up will occur.
- How progress and completion will be monitored.

Shared accountability means the team is collectively responsible for outcomes, but individual action steps should always have a clearly identified owner. Clear ownership helps prevent duplication, missed follow-up, and diffusion of responsibility while maintaining the benefits of multidisciplinary teamwork.

In AFBSS, accountability extends beyond individual caseloads. **The entire team shares responsibility for monitoring outcomes, identifying service gaps, and using data to improve care**. Engagement, retention, safety, and client outcomes should be viewed as collective measures of team performance rather than the responsibility of a single provider. See the section on Quality Improvement and Measuring Success for ideas on tracking outcomes.

COORDINATING CARE ACROSS THE TEAM

Effective care coordination depends on constant communication, shared accountability, and coordinated workflows. While care coordination is a service provided to individuals, successful coordination requires the entire team to work together.

Successful teams:

- Maintain shared awareness of client needs, risks, and priorities.
- Communicate regularly across disciplines.
- Clarify roles and responsibilities while maintaining flexibility.
- Coordinate referrals, appointments, outreach, and follow-up activities.
- Share accountability for engagement, transitions, and treatment outcomes.

- Use documentation to support continuity across providers and care settings.

The goal is not simply to coordinate services, but to ensure individuals experience the team as a unified system of care rather than a collection of separate providers.

Structure	Purpose	Typical Focus
Daily Huddles	Brief team meetings that support daily coordination and rapid decision-making.	– Review daily priorities. – Identify individuals requiring outreach or follow-up. – Discuss safety concerns and high-acuity situations. – Coordinate assignments and workload.
Multidisciplinary Case Conferences	Structured discussions used to coordinate care for individuals with complex or high-acuity needs.	– Review complex cases. – Develop integrated care plans. – Coordinate interventions across disciplines. – Identify and address barriers to engagement.
Team Meetings	Routine meetings that support program operations, communication, and continuous improvement.	– Program operations. – Quality improvement activities. – Workflow issues. – Staffing and resource needs.
Debriefs	Post-event discussions following significant incidents, crises, or challenging situations.	– Review what occurred. – Identify lessons learned. – Improve workflows and communication. – Strengthen team performance.
Informal Care Coordination	Ongoing communication between team members outside of formal meetings.	– Share important updates. – Coordinate appointments and outreach. – Address emerging concerns. – Maintain continuity across providers and settings.
Care Transitions Reviews	Structured planning for individuals transitioning	– Hospital discharges. – Detox or residential treatment transitions.

	between services or levels of care.	– Housing placements. – Warm handoffs to new providers. – Continuity and follow-up planning.
Acuity Review Meetings	Regular review of client acuity and service intensity needs.	– Identify changing risk levels. – Adjust outreach frequency. – Reassign team resources. – Review high-need individuals. – Support caseload management.

USE THIS TOOL

Interested in an example of a case presentation used for team-based settings? See the sample Multidisciplinary Team Meeting Case Presentation Template. > **Tool 6.D**

EVIDENCE-INFORMED MODELS FOR INTEGRATED AND WRAP-AROUND CARE

Several established care models provide useful examples of team-based practices that can inform AFBSS implementation. While AFBSS is distinct from these models, many of their core concepts align with effective field-based substance use disorder services.

ASSERTIVE COMMUNITY TREATMENT (ACT)

Assertive Community Treatment (ACT) is an evidence-based practice to support individuals living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services.

While ACT is not a new model, California is currently expanding implementation of ACT as a distinct service model within the behavioral health system. ACT provides a useful example of how multidisciplinary teams can deliver coordinated, person-centered services in community settings. Forensic ACT (FACT) builds upon the ACT model to address the complex needs of individuals with significant behavioral health needs who are also involved with the criminal justice system. ACT and FACT are key service models in the continuum of Full Service Partnership (FSP) programs designed to provide individualized, team-based comprehensive and

integrated care for persons with significant behavioral health needs including those at high risk for homelessness, justice involvement, and hospitalization.

ACT and FACT teams provide wrap-around mental health and SUD services to the individual and deliver services where and when they are most effective, including in homes, shelters, supportive housing, or other community locations.

Key features of ACT and FACT include:

- **Multidisciplinary teams** that may include social workers, psychologists, peer specialists, substance use specialists, nurses, psychiatrists, and employment specialists.
- **Low staff-to-client ratios** (typically 1:10) supported by adequately sized teams that can share responsibility for this defined population.
- **Frequent and assertive engagement**, often involving multiple contacts per week.
- **Around the clock availability,** meaning 24/7 coverage including after-hours crisis support.
- **Field-based service delivery**, with most services provided in community settings rather than office-based environments.
- **Integrated service delivery** that addresses behavioral health, substance use, physical health, housing, benefits, transportation, and other practical needs.
- **Continuity of care** across treatment, housing, and service settings.
- **Ongoing support that is not time-limited** and can continue as long as the level of service is needed.

ACT and FACT demonstrate how community-based, multidisciplinary teams can organize care around the needs of the individual rather than requiring individuals to navigate multiple disconnected systems. These principles closely align with AFBSS goals related to engagement, integration, continuity of care, and whole-person service delivery.

ENHANCED CARE MANAGEMENT (ECM)

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal Members with the most complex health and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered.

As one of the key components of the California Advancing and Innovating Medi-Cal (CalAIM) program, ECM describes several eligible populations that closely overlap with those commonly served through AFBSS, including individuals experiencing homelessness, people with serious

mental illness or substance use disorders, individuals transitioning from incarceration, and individuals with high utilization of healthcare services.

Like AFBSS, ECM emphasizes whole-person, community-based care that addresses health-related social needs and improves coordination across fragmented service systems. While ECM is primarily a care management benefit rather than a treatment model, it provides a useful example of how multidisciplinary teams can organize services around the needs of individuals with complex challenges.

Key features of ECM include:

- **Community-based engagement**, including meeting individuals in homes, shelters, hospitals, encampments, and other community settings.
- **Whole-person care planning** that integrates physical health, behavioral health, substance use treatment, and social service needs.
- **Intensive care coordination** across healthcare providers, behavioral health services, housing systems, justice systems, and community-based organizations.
- **Person-centered service planning** that incorporates individual goals, preferences, strengths, and priorities.
- **Care transition support**, including coordination following hospitalization, incarceration, residential treatment, or other changes in care settings.
- **Flexible service delivery** that adapts to individual needs rather than requiring individuals to navigate multiple disconnected systems independently.
- **Partnerships with community-based organizations**, including organizations serving people experiencing homelessness, justice-involved populations, and individuals with behavioral health needs.

ECM demonstrates how care coordination, multidisciplinary collaboration, and community-based engagement can improve access to care for individuals with complex needs. These principles closely align with AFBSS goals related to whole-person care, system navigation, service integration, continuity of care, and sustained engagement.

How can AFBSS teams coordinate with ECM teams? An ECM team can also provide AFBSS services. To inquire about providing these services via ECM as an AFBSS team, contact DHCS regarding the process. If the AFBSS team is not also working as an ECM team, communication is key. Identifying a point of contact within the ECM team is important, including coordinating access to medical and specialty services for the client.

DETERMINING WHERE CARE HAPPENS

AFBSS delivers care in the setting most likely to support engagement, safety, and continuity.

ACUTE CARE SETTINGS

Hospitals, emergency departments, and crisis settings provide opportunities to initiate treatment, begin medications, and establish rapid connections to ongoing services. When individuals present to the hospital, universal screening for both mental health (MH) and SUD needs should occur. Prescribers in emergency departments (EDs) and inpatient settings can and should initiate care immediately, including initiation of FDA-approved medications for addiction treatment, while substance use navigators and other peer supports can facilitate warm handoffs to ongoing, community-based services, increasing the likelihood of engagement

FIELD TIP

In acute care settings...

Start treatment and begin discharge planning as early as possible.

In ongoing outpatient care...

Coordinate care across providers and minimize handoffs.

For field-based care...

Deliver services where people live and spend time, including encampments, shelters, supportive housing sites, and other community settings.

ONGOING OUTPATIENT CARE

When individuals can engage consistently with facility-based services, co-located and integrated outpatient care may provide ongoing treatment and monitoring.

FIELD-BASED CARE

For individuals experiencing housing instability, transportation challenges, significant behavioral health symptoms, field-based services often provide the most effective platform for treatment.

Field-based care may occur in:

- Encampments
- Shelters
- Interim housing programs
- Permanent supportive housing
- Community locations
- Other environments where individuals live and spend time

QUALITY IMPROVEMENT AND MEASURING SUCCESS

Quality improvement is an ongoing process that helps AFBSS programs assess whether services are reaching the intended population, reducing barriers to care, improving outcomes, and advancing system goals. Because AFBSS is built on harm reduction, low-barrier access, and person-centered care, success should be measured using a broad set of indicators rather than relying solely on abstinence, treatment completion or existing standardized measures (e.g., Follow-up after emergency department visit for SUD or after hospitalization for MH conditions).

FIELD TIP

Measure what matters to the people you serve.

Look beyond traditional measures to safety, engagement, stability, trust, and progress toward individual goals.

Programs should monitor measures that assess access, engagement, care quality, client outcomes, and equity while using the results to inform continuous quality improvement activities.

HARM REDUCTION



Purpose: Assess whether services are reducing risk and improving safety.

Success: Individuals are safer, better informed, and connected to harm reduction and treatment services.

Example Measures:

- Naloxone distribution and utilization
- Reported overdose reversals
- Overdose prevention education provided
- Distribution of harm reduction supplies
- Use of safer-use practices
- Reduction in overdose events
- Increased engagement in treatment and recovery services
- Increased levels of self-reported improvements
- Initiation or continuation of medications for addiction treatment

ACCESS & TIMELINESS



Purpose: Assess whether individuals can access services when they are ready to engage.

Success: Services are available when and where

Example Measures:

- Same-day or next-day access to services
- Time from first contact to assessment
- Time from assessment to medication initiation
- Walk-in utilization rates

	individuals need them, with minimal delays or barriers.	– Missed opportunities for initiation – Wait times for follow-up services
ENGAGEMENT & RETENTION 	**Purpose:** Assess the program's ability to establish and maintain ongoing relationships. **Success:** Individuals remain connected to services and are successfully re-engaged following periods of disengagement.	**Example Measures:** – Initial outreach-to-engagement rates – Frequency of client contacts – Retention over time – Re-engagement following missed appointments or disengagement – Continued participation among individuals experiencing homelessness, justice involvement, or other high-risk circumstances – Engagement through community partners or trusted messengers
INTEGRATED & WHOLE-PERSON CARE 	**Purpose:** Assess whether substance use, mental health, medical, and social needs are being addressed in a coordinated manner. **Success:** Individuals experience services as coordinated, comprehensive, and responsive to their whole-person needs.	**Example Measures:** – Screening rates for substance use, mental health, and social needs – Referral completion rates – Linkage to primary care – Linkage to behavioral health services – Medication initiation and continuation rates – Cross-disciplinary care plan completion – Follow-up after hospitalization, crisis events, or significant care transitions
FUNCTIONAL OUTCOMES 	**Purpose:** Assess improvements in stability, functioning, and quality of life. **Success:** Individuals experience improved health, stability, independence, and	**Example Measures:** – Housing stability – Employment or educational engagement – Improvements in social determinants of health – Reduced emergency department utilization – Reduced hospitalization

	progress toward personal goals.	– Reduced justice-system involvement – Improved self-reported quality of life – Achievement of self-identified goals
EXPERIENCE & TRUST 	**Purpose:** Assess whether services are delivered in a manner that promotes trust, engagement, and partnership. **Success:** Individuals feel respected, heard, safe, and actively involved in their care.	**Example Measures:** – Client satisfaction – Perceived accessibility of services – Reported trust in providers and staff – Feelings of safety and respect during interactions – Perceived involvement in care planning and decision-making – Staff responsiveness to client needs
EQUITY 	**Purpose:** Assess whether services are reaching priority populations and producing equitable outcomes. **Success:** Services are accessible and effective across populations, particularly those historically underserved or marginalized.	**Example Measures:** – Service utilization across demographic groups – Engagement among individuals experiencing homelessness – Engagement among justice-involved populations – Language access indicators – Cultural responsiveness measures – Outcome differences across demographic groups – Partnerships with trusted community-based organizations
IMPLEMENTATION CAPACITY 	**Purpose:** Assess whether the program has the staffing, resources, training, and partnerships needed to deliver AFBSS. **Success:** The program has the capacity to consistently provide accessible, high-	**Examples Measures:** – Staffing levels and vacancies – Staff training completion – Availability of low-barrier services – Community partnerships – Funding dedicated to harm reduction and outreach services

quality, low-barrier services.

USE THIS TOOL

Ready to plan with quality measures you want to improve? Use the **AFBSS Quality Improvement Measure Planner**.

> **Tool 6.E**

ADDITIONAL RESOURCES

The **Plan-Do-Study-Act (PDSA) Worksheet** is a quality improvement tool that helps teams test changes on a small scale, evaluate results, and make ongoing improvements to workflows, staffing approaches, and service delivery practices.

BEHAVIORAL HEALTH TRANSFORMATION (BHT) PERFORMANCE MEASURES

The BHSA County Policy Manual incorporates the finalized Behavioral Health Transformation (BHT) Performance Measures as part of the state's implementation of Proposition 1. The manual positions BHT as the overarching framework for behavioral health system transformation and includes guidance on how counties should use performance measures to support planning, reporting, accountability, and continuous quality improvement. Counties are encouraged to familiarize themselves with these measures and related resources as they develop and refine local behavioral health strategies.

BHT Performance Measures are being implemented in two phases.

- Phase 1 measures consist of statewide, population-level indicators that reflect broader behavioral health outcomes and are included in counties' initial planning efforts.
- Phase 2 measures, finalized in June 2026, focus specifically on the performance of county behavioral health departments and Medi-Cal managed care plans.

Going forward, counties will use these measures to inform local planning, annual BHSA reporting requirements, and Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) submissions. These measures provide an important framework for assessing progress, identifying opportunities for improvement, and demonstrating the impact of behavioral health investments and services. We recommend that you periodically refer to Section C.3 of the BHSA Policy Manual for any updates.

FRAMEWORK FOR BUILDING HIGH-PERFORMING TEAMS

The TeamSTEPPS® 3.0 curriculum, developed by the Agency for Healthcare Research and Quality (AHRQ), provides a framework for building high-performing teams through four core competencies: communication, leadership, situation monitoring, and mutual support.

The TeamSTEPPS curriculum and Pocket Guide offer concrete communication tools to ensure high-quality patient care and team safety that could be helpful for ABSS teams to implement. These tools can help AFBSS teams establish a shared approach to communication, clarify roles and responsibilities, support effective care transitions, improve situational awareness, and reduce the risk of missed information during outreach, crisis response, care coordination, and multidisciplinary care planning.

USE THIS TOOL

Ready to integrate team-based care using TeamSTEPPS? Use the Team-Based Care and TeamSTEPPS Implementation Planning Worksheet.

> Tool 6.F

SECTION 6 KEY TAKEAWAYS & RESOURCE MAP

- **Harm reduction is both a philosophy and a service delivery approach.** It focuses on reducing harm, increasing safety, and supporting health and well-being regardless of an individual's substance use goals.
- **Engagement is often the first and most important intervention.** AFBSS prioritizes connection, re-engagement, and relationship-building over compliance with treatment expectations.
- **Success starts with what matters to the individual.** Addressing immediate needs and supporting self-identified goals can strengthen trust and create opportunities for ongoing engagement.
- **Safety is prioritized over abstinence.** Overdose prevention, naloxone access, safer-use education, infectious disease prevention, and risk reduction are critical components of care.
- **Low-barrier services reduce obstacles to treatment.** Rapid access, flexible service delivery, field-based care, and removal of unnecessary requirements help individuals access care when they are ready.
- **Shared decision-making and motivational interviewing support engagement.** Individuals are active partners in care planning, treatment decisions, and goal setting.

- **Contingency Management (CM) can strengthen engagement and recovery.** CM uses positive reinforcement to support clearly defined treatment, health, and recovery behaviors and has a particularly strong evidence base for stimulant use disorder.
- **Informed consent remains essential in field-based care.** Consent is an ongoing communication process that supports informed decision-making, voluntary participation, and person-centered treatment.
- **Whole-person care addresses substance use, mental health, physical health, and social needs together.** Integrated service delivery reduces fragmentation and supports better outcomes.
- **Team-based care relies on shared accountability, communication, and coordinated action.** Multidisciplinary teams work together to support engagement, treatment, care coordination, and long-term stability.
- **Success should be measured broadly.** Meaningful outcomes may include increased engagement, improved safety, housing stability, health improvement, reduced crisis utilization, and progress toward self-identified goals.
- **Quality improvement is essential to implementation.** Programs should routinely use data to assess access, engagement, outcomes, equity, and service quality, and apply findings to strengthen AFBSS delivery over time.

IF YOU ARE READY TO…	GO TO…	
Assess how well harm reduction principles are reflected in services	> **Tool 6.A**	Harm Reduction Practice Review
Learn about low barrier models of care with those with SUD	>	Low-Barrier Models of Care for Substance Use Disorders
Reduce barriers to engagement and improve access to care	> **Tool 6.B**	Low-Barrier Service Delivery Self-Assessment
Learn practical approaches for serving people experiencing homelessness and SUD	>	Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder Toolkits (Parts One and Two)
Have and document conversations around consent in the field	> **Tool 6.C**	Consent to Treatment in the Field – Tools
Standardize multidisciplinary case review meetings	> **Tool 6.D**	Multidisciplinary Team Meeting Case Presentation Template (SAMPLE)

Establish a quality improvement strategy and performance measures	> **Tool 6.E**	AFBSS Quality Improvement Measure Planner
Improve communication and teamwork using TeamSTEPPS principles	> **Tool 6.F**	Team-Based Care and TeamSTEPPS Implementation Planning Worksheet

REFERENCES

Agency for Healthcare Research and Quality. (2023). *How to implement team-based care and TeamSTEPPS for field-based substance use disorder treatment* [Implementation resource]. U.S. Department of Health and Human Services.

American Academy of Family Physicians. (2007). Panel size: How many patients can one doctor manage? *Family Practice Management, 14*(4), 44–51. https://www.aafp.org/pubs/fpm/issues/2007/0400/p44.html

American Hospital Association. (2024). *Team training pocket guide*. https://www.aha.org/system/files/media/file/2024/04/TeamTraining_PocketGuide_Feb2024_022824.pdf

American Society of Addiction Medicine, & American Academy of Addiction Psychiatry. (2024). *The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder*. *Journal of Addiction Medicine, 18*(1), 1-56. https://doi.org/10.1097/ADM.0000000000001299

Bond, G. R., Drake, R. E., McHugo, G. J., Peterson, A. E., Jones, A. M., & Williams, J. (2015). The critical ingredients of assertive community treatment. *World Psychiatry, 14*(2), 240–242. https://doi.org/10.1002/wps.20234

Cnop K, Zaks C, Collins S. *Innovations in Addiction Medicine on the Street: SUD Treatments for the Unhoused*. Presented at: American Society of Addiction Medicine (ASAM) Annual Conference; April 25, 2025; San Diego, CA

English, A., & Gudeman, R. (2024). *Minor consent and confidentiality: A compendium of state and federal laws (California)*. National Center for Youth Law. https://youthlaw.org/wp-content/uploads/ncylminorconsentcompendium2024-california.pdf

Heller, S. S., & Gilkerson, L. (Eds.). (2009). *A practical guide to reflective supervision*. ZERO TO THREE.

Institute for Healthcare Improvement. (n.d.). *Model for improvement: Testing changes*. https://www.ihi.org/library/model-for-improvement/testing-changes

Institute for Healthcare Improvement. (n.d.). *Plan-do-study-act (PDSA) worksheet* [Practice tool]. https://www.ihi.org/library/tools/plan-do-study-act-pdsa-worksheet

Medical Group Management Association. (n.d.). *Patient panel size management checklist*. https://www.mgma.com/member-tools/patient-panel-size-management-checklist

Motivational Interviewing Network of Trainers. (n.d.). *Understanding motivational interviewing*. https://motivationalinterviewing.org/understanding-motivational-interviewing

National Center for Youth Law. (2020). *Frequently asked questions about minor consent for substance use disorder (SUD) services in California*. https://www.schoolhealthcenters.org/wp-content/uploads/2020/12/NCYL-SUD-Minor-Consent-FAQ.pdf

National Center for Youth Law. (2023). *California minor consent and confidentiality laws: Quick reference chart*. https://static1.squarespace.com/static/66421681d90ded764d1347e8/t/66a9467522a93e5eb03a0380/1722369655524/2023CaMinorConsentConfChartFull.pdf

National Harm Reduction Coalition. (n.d.). *Principles of harm reduction*. https://harmreduction.org/about-us/principles-of-harm-reduction/

Reproductive Health National Training Center. (2021, December). *OARS model: Essential communication skills job aid*. https://rhntc.org/resources/oars-model-essential-communication-skills-job-aid

Substance Abuse and Mental Health Services Administration. (2024). *Assertive community treatment (ACT): Evidence-based practices toolkit*. U.S. Department of Health and Human Services. https://www.samhsa.gov/resource/ebp/assertive-community-treatment-act-evidence-based-practices-ebp-kit

Substance Abuse and Mental Health Services Administration. (2025). *Using SAMHSA funds to implement evidence-based contingency management services* (Publication No. PEP24-06-001). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/contingency-management-advisory-pep24-06-001.pdf

van Veldhuizen, J. R. (2007). FACT: A Dutch version of ACT. *Community Mental Health Journal, 43*(4), 421–433. https://doi.org/10.1007/s10597-007-9089-4

van Veldhuizen, J. R., & Bähler, M. (2013). *Flexible Assertive Community Treatment (FACT): Vision, model, practice and organization*. CCAF.

SECTION 7:
FIELD-BASED MEDICATION TREATMENT FOR SUBSTANCE USE DISORDERS

PURPOSE

Within the framework of clinical practice and service delivery described in Section 6, medication for addiction treatment (MAT) is a core component of SUD care, helping reduce withdrawal and cravings, decrease substance use and overdose risk, and support recovery. For some individuals served through AFBSS, medication may be the first evidence-based treatment they are able or willing to access. This section provides guidance for field-based MAT and other medication-related approaches, including **procurement, storage, handling, administration, and clinical considerations for alcohol, nicotine, opioid, and stimulant use disorders**, with attention to timely access, safety, regulatory compliance, and continuity of care.

HOW TO USE THIS SECTION

This section provides **practical guidance for planning, implementing, and strengthening field-based medication for addiction treatment (MAT) and other medication treatment services** within AFBSS programs. It includes operational considerations, medication treatment approaches for common substance use disorders, withdrawal management considerations, and implementation resources to support both new and established programs. As you review the content, consider:

- ☑ Do current workflows support safe medication procurement, storage, transportation, administration, and monitoring?
- ☑ Are staff equipped to recognize withdrawal, assess safety concerns, and determine when a higher level of care is needed?
- ☑ How are transitions of care managed to support continuity of medication treatment and ongoing engagement?

Throughout this section, you'll find medication overviews, implementation considerations, withdrawal management guidance, and field-tested tools that can help programs **expand access to evidence-based treatment, improve medication initiation and retention, strengthen operational workflows, and support long-term recovery outcomes.** In addition, MAT protocols are available in Appendices 7.A – 7.F.

GUIDING PRINCIPLES FOR MEDICATION TREATMENT IN AFBSS

The principles described throughout Section 6: Clinical Practice and Service Delivery in AFBSS of this toolkit apply equally to MAT and other medication management approaches. Medication-related decisions should not be viewed as separate from the broader service delivery approach, but rather as one component of comprehensive, person-centered SUD care. When applying those principles to medication treatment, AFBSS teams should focus on the following considerations:

Person-Centered Medication Selection: Medication choices should align with the patient's goals, preferences, clinical needs, and treatment history.

Reducing Barriers to MAT Initiation: Programs should minimize operational barriers that delay medication access and treatment initiation.

Shared Decision-Making: Treatment decisions should be made collaboratively, with patients receiving clear information about available options.

Supporting Ongoing Engagement: Medication treatment should include ongoing follow-up, monitoring, and support beyond initiation.

Harm Reduction Through MAT Access: MAT should remain available regardless of abstinence goals, with treatment plans adjusted as needs change.

Promoting Continuity of Medication Treatment: Teams should prioritize uninterrupted access to medications across care transitions and periods of instability.

ADDITIONAL RESOURCES

The National Clinician Consultation Center (NCCC) has produced helpful resources for clinicians managing medications.

- NCCC Substance Use Resources Webpage – This webpage provides healthcare providers with clinical consultation, guidelines, and tools to support substance use screening, assessment, and treatment. It offers access to expert guidance, training resources, and service locators to help clinicians deliver evidence-based substance use care.
- NCCC Substance Use Management – This resource provides healthcare providers with expert, peer-to-peer consultation on assessing and treating substance use disorders, managing medications, preventing overdose, and addressing complex patient needs. It offers up-to-date, evidence-based guidance from addiction specialists to support informed clinical decision-making and improve patient care.

OPERATIONAL FOUNDATIONS OF FIELD-BASED MEDICATION TREATMENT

Successful field-based MAT and other medication treatment requires operational systems that make medications available quickly while maintaining patient safety, regulatory compliance, and accountability across community settings.

AFBSS programs should establish or periodically review how MAT and other medications used in SUD care are selected, obtained, prescribed, paid for, stored, transported, consented for, administered, tracked, returned, and disposed of. Core requirements for medication handling, storage, and tracking are established at the federal and state levels, including by the Drug Enforcement Administration (DEA), California State Board of Pharmacy, and California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES). Counties and contracted providers should also review applicable local requirements, including local pharmaceutical waste and disposal ordinances and requirements that may vary by facility type under Title 22 of the California Code of Regulations.

Programs developing field-based medication services can use the considerations below to establish their initial policies, partnerships, and workflows.

Programs with existing medication operations can use them to assess current practices, identify gaps, and determine where additional safeguards or access strategies may be needed.

MEDICATION PROCUREMENT

Medication procurement includes the review and selection, purchasing, receipt, verification, payment, and distribution of MAT and other medications used to treat SUD. Programs should establish or assess procurement workflows to ensure they minimize the time between a patient's decision to begin treatment and medication initiation.

Programs should consider whether current procurement procedures adequately address:

- Prescribing and medication-ordering processes.
- Reliable pharmacy partners that maintain sufficient stocks of medications used to treat SUD.
- How medications will be obtained by or delivered to the patient or care team.
- Payer coverage, authorization, and billing requirements.
- Alternate access pathways when a medication is unavailable from the preferred pharmacy.

- Processes for promptly resolving pharmacy, payer, or supply barriers that could delay treatment.

Pharmacy partners should maintain adequate medication inventory and be prepared to serve patients with SUD respectfully, with dignity, and without stigma. Stigma toward patients with SUD or patients using medications for addiction treatment may affect access, including when pharmacies decline to stock certain medications or maintain only limited supplies. Depending on geography, pharmacy capacity, and the size of the patient population, programs may need to establish relationships with more than one pharmacy.

Programs should also consider whether recurring outreach and education for pharmacy staff are needed. This may be particularly important when a program uses nontraditional medication initiation approaches or medications prescribed off-label* for SUD, such as topiramate for alcohol or stimulant use disorder. Establishing a reliable pharmacy contact who can help resolve prescription, inventory, delivery, or coverage issues may reduce treatment delays.

Note on Off-Label Medications*

While the FDA may have approved a medication, off-label use describes the practice of prescribing for a purpose, condition, age group, dosage, or route of administration that differs from what was officially approved by the FDA. It is legal and common for licensed healthcare providers to prescribe approved drugs for off-label uses when supported by sound scientific evidence and medical judgment.

Similar education may be needed for payers unfamiliar with addiction medications, nontraditional initiation protocols, off-label prescribing, or the operational needs of field-based treatment. Programs should establish or review processes for addressing prior authorizations, rejected claims, formulary limitations, quantity restrictions, and other coverage barriers before those issues prevent timely initiation.

At a minimum, medication access plans should address:

- Patient pickup from a pharmacy.
- Pickup and appropriate storage by an authorized care team member.
- Pharmacy delivery to the provider's office for field administration.
- Lack of availability through the usual pharmacy.
- Inability to resolve coverage or authorization when the patient is ready to begin treatment.

MEDICATION STORAGE

Programs should establish or review storage procedures to ensure that medications are maintained according to FDA-approved manufacturer labeling and applicable federal, state, local, and organizational requirements. Storage systems should preserve medication integrity, prevent unauthorized access, and reduce the risk of loss or diversion.

Controlled substances should be stored in a secure location behind two locks, such as a locked cabinet or safe located behind a locked door. Storage equipment used for controlled substances should meet applicable **DEA requirements** related to security and construction. Access to medication storage areas, particularly those containing controlled substances, should be limited to the minimum number of authorized personnel necessary to support program operations.

Programs storing refrigerated medications should confirm that their procedures address:

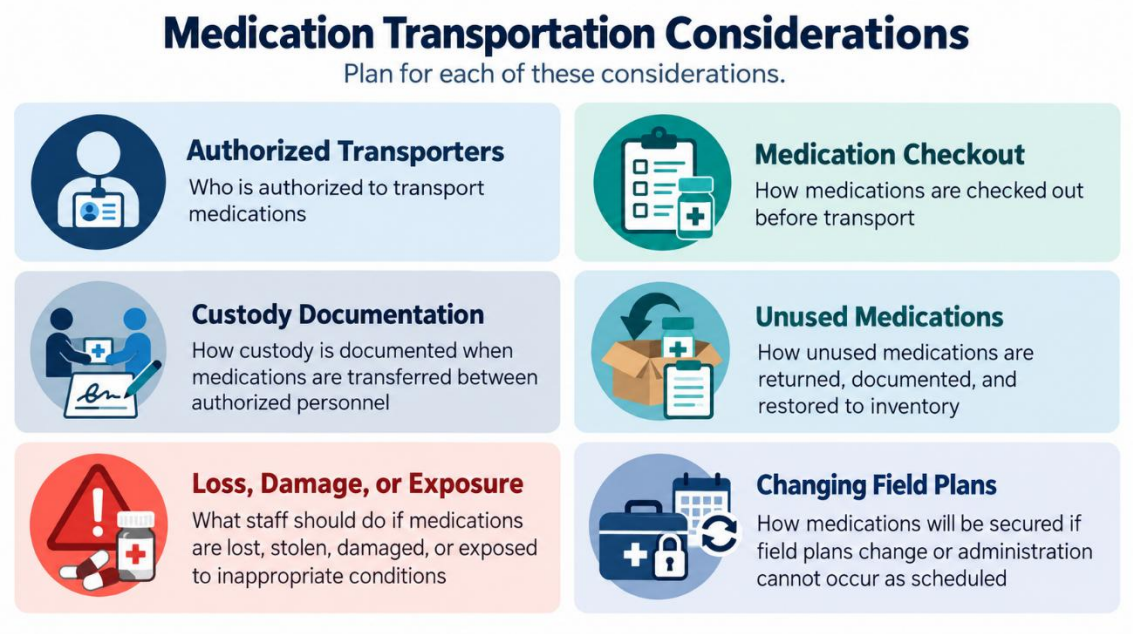
- Storage of refrigerated controlled substances in a locked refrigerator or locked compartment within a medication refrigerator.
- Use of the refrigerator exclusively for medication storage.
- Establishing, monitoring, and documentation of refrigerator temperatures daily in accordance with organizational policies and manufacturer requirements.
- Maintenance of temperature logs.
- Response procedures for temperature excursions, power outages, equipment failures, or other conditions that may affect medication integrity.

Programs should establish procedures for monitoring storage conditions and identifying medications that are expired, damaged, recalled, returned, or temperature-compromised. Policies should identify how these medications will be secured, documented, removed from active inventory, and disposed of in accordance with applicable requirements.

MEDICATION TRANSPORTATION

AFBSS programs should establish or review procedures for transporting medications from pharmacies, provider offices, or storage sites to community locations. These procedures should maintain medication security, preserve required storage conditions, and document medication movement when necessary.

Medications, particularly controlled substances, should be transported in tamper-evident, locked containers or medical bags and kept in the custody of authorized personnel whenever possible.



Programs should also assess whether transportation practices adequately account for temperature conditions in the field. Teams should use insulated transport bags with calibrated temperature-monitoring devices for medications sensitive to heat or freezing. Workflows should specify how staff will document temperatures and respond when a medication is exposed to conditions outside the manufacturer's recommended range.

Medications should not be left unattended in vehicles or unsecured field locations. Programs should have procedures for safely returning medications when a visit is canceled, the patient is unavailable, the medication cannot be administered, or field conditions make administration unsafe.

MEDICATION ADMINISTRATION

Medication administration procedures should define staff roles, scope-of-practice requirements, supervision expectations, documentation responsibilities, and procedures for responding to adverse events. Programs establishing these procedures, as well as those reviewing established practices, should confirm that medications are prescribed, prepared, verified, administered, and documented by personnel acting within their authorized scope of practice and in accordance with applicable laws, regulations, and organizational policies.

In California:

- Licensed independent practitioners, including physicians, osteopathic physicians, nurse practitioners, and physician assistants, may prescribe and administer medications in the field within their respective scopes of practice.

- Registered nurses (RNs) may administer medications under the direct order of a licensed practitioner.
- Licensed vocational nurses (LVNs) may administer medications under the direct supervision of a physician, surgeon, naturopathic doctor, or registered nurse.
- Medical assistants (MAs) may administer medications in the field after a licensed practitioner verifies the correct medication and dosage before administration.
- Unlicensed team members are generally limited to assisting patients with self-administration.

Unlicensed team members may still support field-based medication administration through patient engagement, scene management and safety, transportation coordination, and assistance in establishing an appropriate environment for administration.

Field Administration Workflows

Programs should establish or review field administration workflows to address:

- Obtain informed consent from the patient (see **Informed Consent in Field-Based Settings** section of the Toolkit).
- Verification of the correct patient, medication, dose, route, and timing.
- Assessment of whether the field environment is appropriate for safe administration.
- Documentation of medication administration or supported self-administration.
- Monitoring required before and after administration.
- Identification and response to adverse effects or changes in clinical status.
- Emergency response procedures and supplies appropriate to the medication and setting.
- Documentation and follow-up when a dose is declined, delayed, missed, or unable to be administered.
- Coordination among the prescribing clinician, administering staff member, pharmacy, and other members of the care team.

Field staff should understand when administration can proceed safely and when environmental, clinical, staffing, or security concerns require a different location, additional support, or a higher level of care.

CHAIN OF CUSTODY AND INVENTORY MANAGEMENT

Programs should establish or assess chain-of-custody and inventory practices for tracking medications from procurement through storage, transportation, administration, return, or disposal.

Inventory systems should document, as applicable:

- Medication receipt and verification.
- Medication name, strength, quantity, lot number, and expiration date.
- Placement into and removal from storage.
- Transport between locations.
- Transfer between authorized personnel.
- Dispensing or administration.
- Return of unused medication.
- Waste or disposal.
- Inventory discrepancies.
- Recalls and changes in medication status.

Inventory procedures should include sign-in and sign-out logs documenting the date, time, medication, patient, authorized staff member's name, and signature, as applicable. Programs should designate responsibility for inventory oversight and review inventory records regularly.

Inventory reviews should compare physical inventory with medication records and verify:

- Medication counts.
- Lot numbers.
- Expiration dates.
- Recall status.
- Storage conditions.
- Refrigerator temperatures, when applicable.
- Chain-of-custody documentation.
- Discrepancies between physical inventory and inventory records.

High-alert medications and controlled substances require enhanced documentation procedures. These may include medication counts, transfer records, sign-in/sign-out logs, and multi-signature verification when medications are issued, transferred, returned, wasted, or disposed of.

Organizational policies should also address:

- Investigation and reconciliation of inventory discrepancies.
- Reporting of medication loss, theft, tampering, or suspected diversion.

- Response to medication recalls.
- Management of damaged, expired, returned, or temperature-compromised medications.
- Documentation of medication waste and disposal.
- Review of recurring issues and implementation of corrective actions.

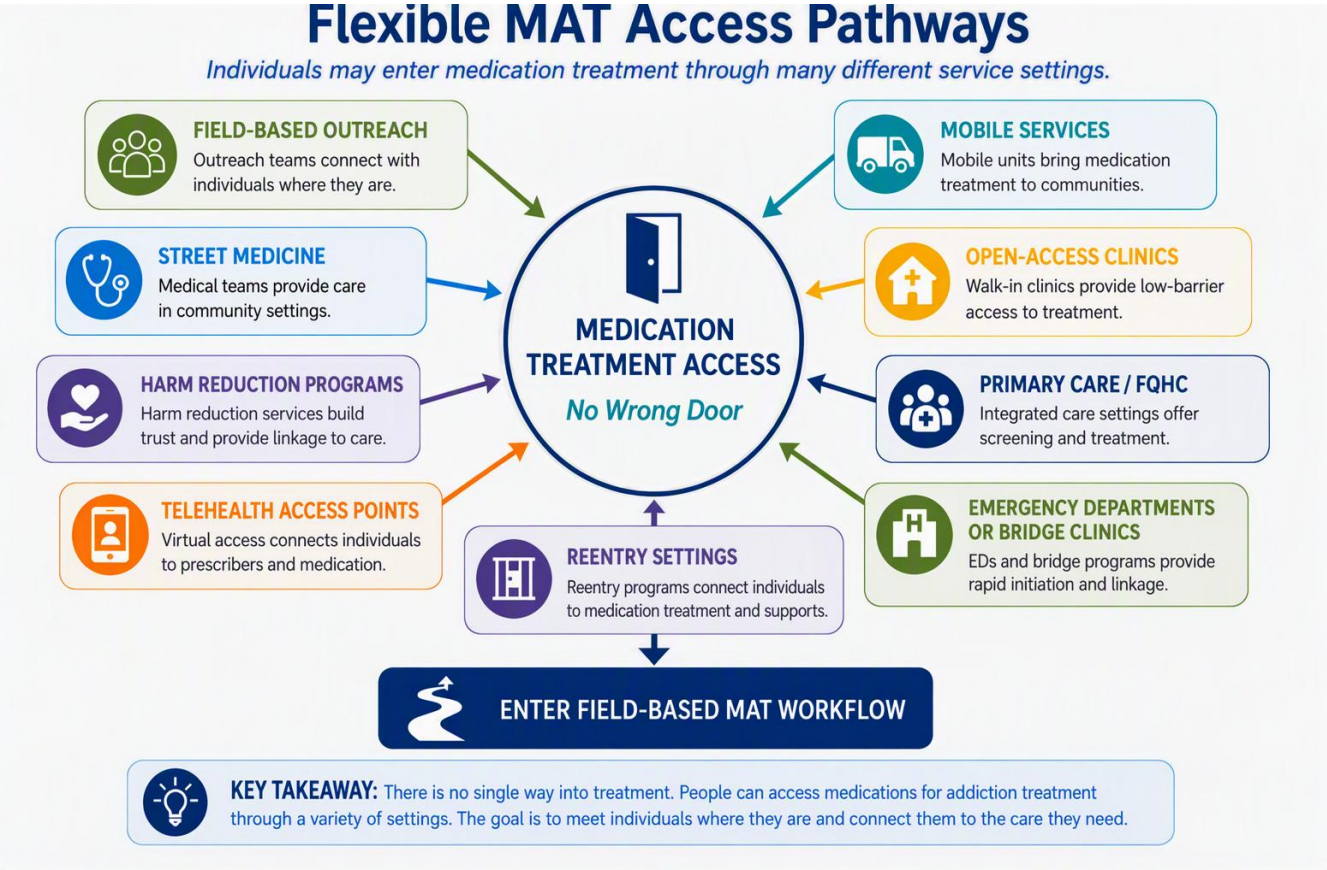
Because medication storage, transportation, administration, and inventory requirements may vary by medication type, facility type, and local jurisdiction, programs should involve appropriate clinical, pharmacy, legal, compliance, and risk-management personnel when establishing or periodically reviewing their chain-of-custody and inventory management procedures.

For substance-specific MAT guidance, medication protocols, and implementation tools, see Appendices 7.A – 7.F.

DESIGNING MULTIPLE PATHWAYS TO MAT AND OTHER MEDICATION ACCESS

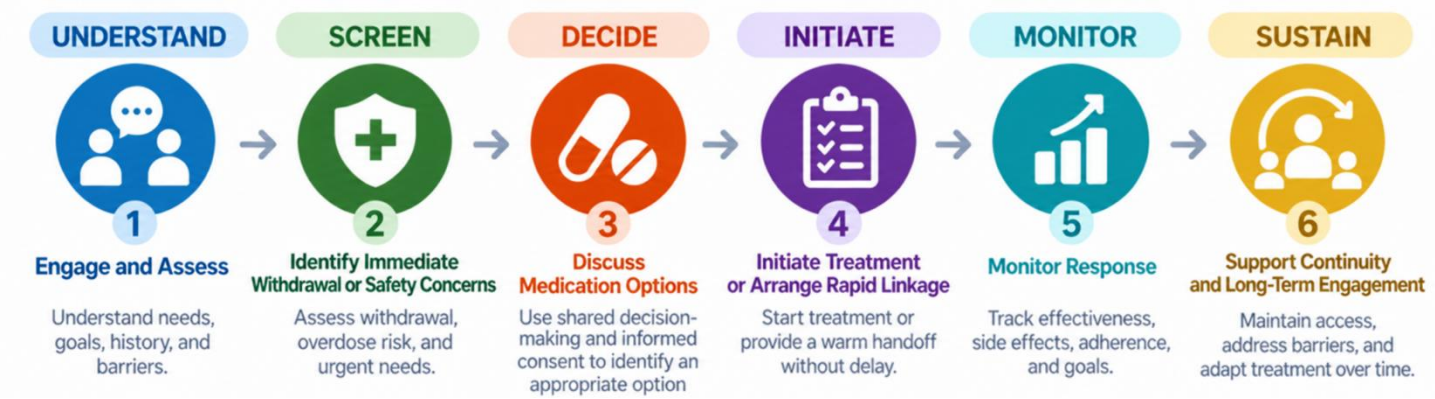
Individuals who face barriers to facility-based treatment may need multiple pathways to initiate and continue MAT. Counties and providers may expand access through field-based and mobile services, street medicine programs, telehealth-supported prescribing, open-access clinics, emergency department bridge programs, and medication access or navigation lines. The appropriate combination will depend on local needs, geography, workforce capacity, prescriber availability, pharmacy access, and existing service infrastructure.

These pathways should not operate as stand-alone prescribing services. MAT and other medication initiation are most effective when connected with outreach, timely assessment, medication access, follow-up, care coordination, and continued treatment support. Programs should define how individuals will move between field-based, virtual, emergency, clinic-based, and ongoing treatment settings without experiencing unnecessary delays or repeated intake processes.



FIELD-BASED MEDICATION TREATMENT WORKFLOW

While MAT and other medication treatment plans vary based on the substance involved, patient goals, clinical presentation, and available resources, most field-based medication services follow a similar progression. The workflow below provides a framework for how AFBSS teams can support medication treatment from initial engagement through ongoing care.



1. Engage and Assess

Medication treatment begins with engagement and assessment. Teams should establish rapport and gather information about substance use patterns, treatment goals, previous treatment experiences, medical and psychiatric history, current medications, and potential barriers to care. Assessment should also identify factors that may affect medication selection, initiation, adherence, follow-up, or safety. It should also include a discussion of strengths and facilitators.

2. Identify Immediate Withdrawal or Safety Concerns

Before initiating treatment, teams should evaluate for acute intoxication, withdrawal syndromes, overdose risk, and other urgent medical or psychiatric concerns that may require immediate intervention or a higher level of care. Withdrawal risk and management considerations vary significantly by substance and are discussed in greater detail throughout this section.

3. Discuss Medication Options

Medication options should be reviewed using a shared decision-making and informed consent approach that incorporates the patient's goals, preferences, clinical needs, and treatment history. Discussions should include the potential benefits, risks, side effects, monitoring requirements, and practical considerations associated with available medications. Medication selection should reflect both clinical appropriateness and the patient's circumstances, including housing status, transportation, follow-up capacity, and ability to store or manage medications safely.

FIELD TIP

Although these steps are presented sequentially, field-based medication treatment is often iterative rather than linear. Patients may move back and forth between stages as their goals, circumstances, and treatment needs change. AFBSS teams should remain flexible and responsive, maintaining engagement and supporting access to treatment regardless of where an individual is in their recovery journey.

4. Initiate Treatment or Arrange Rapid Linkage

When clinically appropriate and operationally feasible, MAT or other medication treatment should be initiated as quickly as possible. If the AFBSS team is unable to provide the medication directly, staff should facilitate rapid linkage to the appropriate provider, pharmacy, opioid treatment program, or higher level of care. Programs should prioritize warm handoffs and active care coordination whenever possible to reduce delays and support successful treatment initiation.

5. Monitor Response & Withdrawal Symptoms

Following initiation, treatment response should be monitored through ongoing assessment of symptoms, medication effectiveness, side effects, adherence, and patient-reported goals. The

frequency and intensity of monitoring should be individualized based on the medication being used, patient-specific risk factors, and available staffing resources.

6. Support Continuity and Long-Term Engagement

MAT and other medication treatment are most effective when it is incorporated into a broader continuum of care. AFBSS teams should support ongoing engagement, address barriers to retention, assist with transitions between care settings, and help patients maintain access to medications over time. Treatment plans should be adjusted as needs evolve, recognizing that recovery is not always linear and that changes in treatment goals, medication selection, or service intensity may be appropriate throughout the course of care.

BUILDING A THERAPEUTIC ALLIANCE AROUND MEDICATION TREATMENT

Many individuals served by AFBSS have had prior experiences with healthcare, behavioral health, or substance use treatment that affect how they view medications and treatment providers. Many may have experienced stigma, coercion, inadequate dosing regimens, untreated side effects, fragmented care, or medications that were ineffective or poorly explained. Building a strong therapeutic alliance can help patients feel supported as they consider MAT and other medication treatment options.

AFBSS teams can strengthen engagement by focusing on the following approaches:

- **Use a nonjudgmental and respectful approach.** Conversations about medications should be grounded in curiosity, respect, and harm reduction. Patients should not be pressured to start, continue, or discontinue medications and should feel comfortable expressing concerns or preferences.
- **Focus on the patient's goals, not the provider's goals.** Medication discussions should begin with what the patient hopes to achieve, whether that is avoiding withdrawal, reducing use, improving health, increasing housing stability, reducing overdose risk, or pursuing abstinence.
- **Take previous medication experiences seriously.** Patients may have stopped medications due to side effects, lack of effectiveness, inadequate dosing regimens, cost, stigma, logistical barriers, or previous negative interactions with providers. Understanding these experiences can help guide future treatment decisions and avoid repeating past challenges.
- **Acknowledge mistrust and treatment fatigue.** Some individuals have been offered treatment repeatedly without feeling heard or supported. Recognizing this history can help normalize hesitation and create opportunities for more meaningful engagement.

- **Use peer support workers whenever possible.** Peers can help normalize MAT, share lived experience, address misconceptions, and demonstrate that recovery pathways differ from person to person. Peer involvement may be particularly valuable for individuals who are skeptical of traditional healthcare systems.
- **Provide clear, understandable information.** Patients should receive practical information about expected benefits, potential side effects, how medications work, and what to expect during treatment. Information should be offered in plain language and revisited over time.
- **Respect ambivalence and readiness for change.** Patients do not need to be fully committed to recovery or abstinence to benefit from medication treatment. Ongoing conversations often build trust and readiness over time.
- **Follow through on commitments.** Consistency, reliability, and responsiveness help build credibility. Simple actions such as returning calls, keeping appointments, resolving pharmacy barriers, or checking in after medication initiation can strengthen trust.

Trust is often the intervention before the medication. Patients are more likely to consider, initiate, and remain engaged in treatment when they feel heard, respected, and included in decisions about their care.

SUBSTANCE-SPECIFIC SUD MEDICATIONS & CONSIDERATIONS

MAT may include different medications and treatment approaches depending on the substance involved, the evidence base, and the individual's goals and clinical needs. The following subsections describe substance-specific options and implementation considerations.

MEDICATIONS FOR ALCOHOL USE DISORDER

Effective MAT options are available to support reduction in alcohol use, abstinence, and recovery goals, yet many individuals remain untreated.

Several effective medications are available for alcohol use disorder, and treatment should be individualized based on the patient's goals, medical history, substance use patterns, prior treatment experiences, and ability to adhere to treatment. Medication effectiveness should be reviewed regularly, and treatment plans should be adjusted as patient goals, clinical needs, and circumstances evolve.

- **Naltrexone** may be appropriate for patients who want to reduce heavy drinking or support abstinence and can be initiated even if a patient is still drinking. It is generally not appropriate for patients currently using opioids.
- **Acamprosate** is often used to support abstinence following withdrawal and may be particularly useful for individuals with liver disease because it is cleared through the kidneys.

- **Disulfiram** may be appropriate for highly motivated individuals whose goal is abstinence and who understand the consequences of alcohol exposure while taking the medication.
- **Topiramate** and **gabapentin** are sometimes used off-label when first-line medications are not effective, tolerated, or clinically appropriate. These medications may also be useful in selected patients with co-occurring symptoms such as insomnia, anxiety, or other clinical considerations.

USE THIS TOOL

Ready to review more detailed medication guidance for AUD? See the Medications for Alcohol Use Disorder Quick Reference Guide. > **Tool 7.A**

Alcohol Withdrawal Management

Alcohol withdrawal can occur after the abrupt cessation or reduction of heavy and prolonged alcohol use. While many individuals experience mild symptoms, alcohol withdrawal can progress to seizures, delirium tremens, medical complications, and death if not recognized and treated appropriately.

Patients with mild to moderate symptoms, stable medical and psychiatric conditions, reliable follow-up, and a safe environment may be appropriate for ambulatory withdrawal management. Withdrawal severity can be assessed using validated tools such as the Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar).

What to look for:

- Tremors
- Sweating
- Anxiety
- Insomnia
- Nausea or vomiting
- Agitation
- Hallucinations
- Changes in orientation or mental status

When to escalate

- Seizures
- Hallucinations, confusion, or delirium
- Severe agitation
- Persistent vomiting
- Unstable vital signs
- Syncope
- Worsening medical or psychiatric symptoms
- Inability to maintain hydration
- Inability to participate in follow-up
- Worsening symptoms despite treatment

Withdrawal management should be viewed as the beginning of treatment rather than the endpoint. AFBSS teams should use withdrawal encounters as an opportunity to initiate or connect individuals to ongoing alcohol use disorder treatment, including behavioral supports, recovery services, and medications when appropriate.

USE THIS TOOL

Ready to assess and treat alcohol withdrawal? Reference the Alcohol Withdrawal Management Quick Reference Guide.

> **Tool 7.B**

ADDITIONAL RESOURCES

Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) is a clinician-administered tool used to assess alcohol withdrawal severity and guide treatment decisions. The CIWA-Ar can support identification of patients who may be appropriate for ambulatory management and those requiring a higher level of care.

MEDICATIONS FOR TOBACCO/NICOTINE USE DISORDER

Nicotine use is common among individuals with substance use disorders and is a leading cause of preventable disease and death. Tobacco use frequently co-occurs with the behavioral health, medical, and social challenges addressed through AFBSS.

Effective medications are available and can significantly improve quit rates, particularly when combined with behavioral support. Importantly, addressing nicotine use during treatment for other substance use disorders does not appear to undermine recovery and may improve long-term outcomes.

Most nicotine treatment regimens continue for at least 12 weeks, and some individuals benefit from longer treatment durations to reduce the risk of return to use. Like returned use of other substances, nicotine use should be viewed as an opportunity to reassess treatment and adjust the treatment plan rather than as treatment failure.

Several effective medication options are available for nicotine use disorder, and treatment should be individualized based on patient preference, prior quit attempts, co-occurring conditions, treatment goals, and potential contraindications.

- **Varenicline** is often considered the most effective single-medication option for tobacco cessation and may be particularly useful for patients seeking a non-nicotine treatment approach.
- **Combination nicotine replacement therapy (NRT)**, typically a nicotine patch combined with a short-acting nicotine product such as gum or lozenges, is an effective and widely accessible treatment option that can often be initiated quickly in community settings.
- **Bupropion** may be a good option for patients who prefer a non-nicotine medication or who have co-occurring depressive symptoms.

AFBSS teams should routinely monitor treatment response, withdrawal symptoms, cravings, side effects, and ongoing tobacco use. If a medication is ineffective or not well tolerated, switching medications or combining treatment approaches may be appropriate.

USE THIS TOOL

Ready to review more detailed medication guidance for tobacco/nicotine use? See the Medications for Nicotine/Tobacco Use Disorder Quick Reference Guide.

> **Tool 7.C**

Implementation Considerations for Medications for Tobacco/Nicotine Use Disorder

Concurrent Treatment with Other Substance Use Disorders

Nicotine treatment should not be delayed because a patient is receiving treatment for another substance use disorder. Evidence suggests that addressing nicotine use during treatment for alcohol or other substance use disorders does not negatively affect recovery and may improve long-term outcomes.

Behavioral Supports

Medication treatment is most effective when combined with behavioral support. Programs should encourage the use of counseling, quitlines, text-based support programs, peer support, and other evidence-based cessation resources whenever available.

Nicotine Withdrawal

Nicotine withdrawal commonly includes cravings, irritability, anxiety, restlessness, and difficulty concentrating. Although uncomfortable, nicotine withdrawal is generally not medically dangerous. Medications for nicotine use disorder help reduce withdrawal symptoms and cravings, and AFBSS teams should encourage continued treatment and support through periods of withdrawal and return to use.

MEDICATIONS FOR OPIOID USE DISORDER

Because many individuals served through AFBSS are not engaged in traditional healthcare settings, field-based services create an important opportunity to offer rapid access to MAT, including medications for opioid use disorder (MOUD). Timely initiation of MOUD can reduce overdose risk, decrease opioid use and associated harms, improve treatment retention, and support long-term recovery. Increasingly, many medication initiation approaches can be implemented in ambulatory and field-based settings, creating opportunities to engage individuals who may otherwise remain disconnected from care.

- **Buprenorphine** is often considered a first-line treatment option because it reduces withdrawal symptoms and cravings, lowers overdose risk, and can frequently be initiated in ambulatory and field-based settings. Multiple initiation approaches are now available, allowing treatment to be tailored to patient needs and circumstances.
- **Methadone** remains one of the most effective medications for opioid use disorder and may be preferred for some patients, particularly those who have not achieved their treatment goals with other approaches or who benefit from the structure of daily opioid treatment program (OTP) services. Access requires coordination with a federally certified opioid treatment program.
- **Extended-release naltrexone** may be appropriate for individuals who have already completed opioid withdrawal and prefer a non-opioid treatment approach. Because it blocks opioid receptors, it can provide protection against the effects of opioids if return to use occurs, but it cannot be initiated until physical opioid dependence has resolved.

No single medication is appropriate for every patient. Treatment effectiveness, patient goals, opioid use, medication adherence, and side effects should be reviewed regularly, with treatment plans adjusted as clinical needs and circumstances evolve.

USE THIS TOOL

Ready to review more detailed medication guidance for OUD? See the Medications for Opioid Use Disorder Quick Reference Guide.

> **Tool 7.D**

Implementation Considerations for OUD Medications

Initiation Approaches for Buprenorphine

Several initiation approaches for buprenorphine are now available and used in clinical practice, including low-dose overlap strategies, withdrawal-based initiation, and long-acting injectable formulations. Programs should be familiar with multiple strategies and be prepared to discuss

multiple initiation approaches. Patients should be engaged in shared decision-making regarding treatment options and programs should select the approach that best aligns with the patient's goals, recent opioid use, clinical circumstances, and treatment preferences.

USE THIS TOOL

Ready to consider how buprenorphine treatment could be initiated? See the **Buprenorphine Initiation Checklist**.

> **Tool 7.E**

Coordination with OTPs for Methadone Access

Because methadone for OUD is generally dispensed through federally certified OTPs, field-based providers often play an important role in referral, engagement, and care coordination rather than direct methadone prescribing.

AFBSS teams can support methadone treatment by:

- Identifying patients who may benefit from methadone.
- Facilitating rapid linkage to OTPs.
- Addressing transportation and logistical barriers.
- Supporting ongoing engagement between OTP visits.
- Coordinating care during transitions between healthcare, housing, and correctional settings.

Partnerships with local opioid treatment programs are critical because methadone remains one of the most effective treatments for OUD. Counties and providers should establish referral pathways, communication processes, and care coordination workflows that support rapid access to OTP services.

Mobile methadone delivery models have expanded access in some communities and may improve engagement among underserved populations, including individuals experiencing homelessness. Counties are encouraged to work with local OTP partners to understand available mobile treatment options and opportunities for collaboration.

Pharmacy and Medication Access Considerations

Programs should establish pharmacy partnerships that support timely access to buprenorphine, injectable formulations, and other medications used in OUD treatment. This includes developing processes to address medication shortages, prior authorization requirements, insurance barriers, and pharmacy familiarity with newer initiation approaches.

Follow-Up and Retention Support

Initiating medication is only the first step in treatment. Ongoing outreach, care coordination, and relationship-building are often necessary to maintain engagement, particularly during the first several weeks following treatment initiation. Teams should proactively address barriers related to transportation, communication, medication storage, housing instability, and competing health or social needs.

Diversion Considerations

Programs should develop strategies that balance diversion prevention with low-barrier access to treatment. This may include patient education, medication monitoring, follow-up visits, CURES review as appropriate, and ongoing discussion regarding safe medication storage and handling. Concerns about diversion should not become a barrier to offering evidence-based treatment when clinically appropriate.

ADDITIONAL RESOURCES

Emergency Department Direct-to-Inject Buprenorphine from the California Bridge to Treatment includes dosing recommendations provides implementation-ready protocols and clinical resources for buprenorphine initiation, high-dose treatment approaches, long-acting injectable formulations, withdrawal assessment, and rapid treatment engagement. These resources can support both new and established field-based programs.

Opioid Withdrawal

Opioid withdrawal is generally not life-threatening. However, it can be profoundly uncomfortable and is a common reason patients return to opioid use, which for some patients could be fatal. Withdrawal assessment is particularly important because it often informs medication initiation decisions.

Withdrawal Assessment

AFBSS teams should assess for opioid withdrawal symptoms when evaluating readiness for medications for opioid use disorder (MOUD). Common symptoms include:

- Muscle aches.
- Gastrointestinal distress.
- Sweating.
- Restlessness.
- Anxiety.

- Insomnia.
- Cravings.

ADDITIONAL RESOURCES

The Clinical Opiate Withdrawal Scale (COWS) is an 11-item clinician-administered tool used to assess opioid withdrawal severity and guide buprenorphine initiation decisions.

The Subjective Opiate Withdrawal Scale (SOWS) is a patient-reported assessment tool that can help monitor opioid withdrawal symptoms and support self-directed or unobserved buprenorphine initiation.

Withdrawal and Buprenorphine Initiation

The timing and severity of withdrawal may influence the buprenorphine initiation approach selected. Some treatment approaches require patients to be in moderate withdrawal before initiation, while others allow treatment to begin before significant withdrawal develops.

Programs should be familiar with multiple initiation approaches and select the strategy that best fits the patient's goals, opioid use pattern, prior treatment experiences, and treatment setting.

Supporting Patients Through Withdrawal

Even when medications are not initiated immediately, AFBSS teams can play an important role in helping patients navigate withdrawal, maintain engagement, reduce overdose risk, and successfully transition to ongoing treatment.

MEDICATIONS FOR STIMULANT USE DISORDER (StUD)

Methamphetamine and cocaine use increasingly contribute to overdose deaths, particularly as the drug supply becomes contaminated with fentanyl and other substances. Individuals experiencing homelessness are disproportionately affected and may use stimulants for safety, energy, emotional regulation, or to manage untreated behavioral health symptoms.

Unlike alcohol use disorder and opioid use disorder, there are currently no FDA-approved medications for stimulant use disorder (StUD). As a result, evidence-based behavioral interventions (for example, contingency management (CM)) remain the foundation of treatment.

CM is the most effective treatment currently available for StUD and is considered the standard of care by ASAM and AAAP. Multiple systematic reviews have consistently demonstrated superior outcomes compared with all other interventions studied. CM reinforces positive behaviors using tangible incentives. For more information, please see the Contingency Management section of the Toolkit.

Evidence demonstrates improvements in:

- Treatment attendance.
- Treatment retention.
- Stimulant-negative urine drug tests.
- Continuous abstinence.
- Recovery engagement.

Examples of rewarded behaviors include:

- Negative urine drug tests.
- Attending counseling visits.
- Completing medical appointments.
- Participating in recovery activities.

Best practices

- Deliver incentives immediately after target behaviors.
- Use rewards of adequate value.
- Combine CM with other behavioral therapies, such as cognitive behavioral therapy (CBT) whenever possible.
- Programs requiring 2–3 contacts weekly demonstrate the greatest effectiveness.

Because no medications are currently FDA-approved for StUD, the medication approaches discussed below should not be characterized as established MAT for StUD. Behavioral interventions, particularly contingency management, remain the foundation of care, while medications may be considered off-label for selected individuals. However, there are several medications that have demonstrated modest benefits in selected populations and may be considered when behavioral interventions alone are insufficient.

- **Bupropion** may be particularly useful for patients with co-occurring depression or tobacco use disorder.
- **Extended-release naltrexone combined with bupropion** currently has some of the strongest medication-related evidence for methamphetamine use disorder, although treatment remains off-label.
- **Topiramate** and **mirtazapine** may be considered for selected patients based on co-occurring symptoms and clinical needs.
- **Modafinil** has shown limited benefit in some populations but does not currently have a clearly defined role in routine treatment.
- **Prescription psychostimulants** should generally be reserved for specialty addiction medicine or addiction psychiatry settings and require careful assessment and monitoring.

Several medications (including glucagon-like peptide-1 receptor agonists and ketamine) are being actively investigated as potential treatments for StUD. Although early research is promising, none of these therapies are currently recommended as standard treatment, and additional randomized controlled trials are needed to establish their safety, effectiveness, and appropriate role in clinical practice. At this time, these medications should generally be considered investigational or reserved for specialized clinical settings, and they should not replace evidence-based behavioral interventions such as contingency management.

USE THIS TOOL

Ready to review more detailed medication guidance for StUD? See the **Pharmacologic Treatment for StUD.** > **Tool 7.F**

ADDITIONAL RESOURCES

The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder provides evidence-based recommendations for the assessment and treatment of stimulant use disorder, stimulant intoxication, and stimulant withdrawal. It identifies **contingency management as the current standard of care** and discusses the potential role of off-label medications in selected patients. It also includes recommendations on harm reduction, withdrawal management, and treatment planning.

Practical Implementation Considerations for StUD Medications

Behavioral Treatment Remains Primary

Because there are no FDA-approved medications for stimulant use disorder, behavioral interventions should remain the primary focus of treatment. Medication treatment, when used, should augment rather than replace evidence-based behavioral approaches.

Psychiatric Assessment

Individuals with stimulant use disorder frequently experience co-occurring psychiatric conditions, including depression, anxiety, psychosis, trauma-related disorders, and attention deficit hyperactivity disorder (ADHD). Comprehensive assessment and ongoing monitoring of psychiatric symptoms should be incorporated into treatment planning.

Monitoring

When medications are prescribed, programs should establish monitoring plans appropriate to the medication being used. Monitoring may include:

- Blood pressure and heart rate.
- Psychiatric symptoms.
- Sleep and appetite.
- Treatment adherence.
- Side effects.
- Substance use patterns.
- Ongoing assessment of risks and benefits.

Diversion Risk

Some medications used off-label for stimulant use disorder, particularly prescription psychostimulants, carry diversion and misuse risks. Programs should establish appropriate monitoring procedures and ensure that prescribing decisions are supported by clear clinical rationale and follow-up plans.

Coordination with Specialty Prescribers

Because many medication treatment approaches remain off-label and continue to evolve, AFBSS teams may benefit from consultation or collaboration with addiction medicine physicians, addiction psychiatrists, or other clinicians experienced in treating stimulant use disorder.

Acute Stimulant Withdrawal

Stimulant withdrawal is generally not medically dangerous but can be physically and psychologically distressing. Symptoms commonly include fatigue, depression, anxiety, sleep disturbance, irritability, increased appetite, and intense stimulant cravings.

Supportive Care and Monitoring

Because there are no approved medications specifically for stimulant withdrawal, management focuses on supportive care and continued engagement in treatment. AFBSS teams may assist patients by providing:

- Reassurance and education about expected symptoms.
- Support around sleep, hydration, and nutrition.
- Ongoing engagement and recovery support.
- Connection to behavioral health services when indicated.

Psychiatric and Safety Assessment

Particular attention should be given to depression, suicidality, psychosis, and other psychiatric symptoms that may emerge or worsen during stimulant withdrawal. Patients experiencing significant psychiatric distress or safety concerns should be connected to appropriate behavioral health or emergency services.

Transition to Ongoing Treatment

Withdrawal support should be paired with discussion of longer-term treatment options, including contingency management, behavioral interventions, recovery supports, and ongoing assessment of whether off-label medication options may be appropriate.

SECTION 7 KEY TAKEAWAYS & RESOURCE MAP

- **MAT should be person-centered.** Medication choices should align with each individual's goals, preferences, clinical needs, and readiness for change, using shared decision-making throughout treatment.
- **Rapid MAT access improves engagement.** Programs should minimize operational, pharmacy, and payer barriers that delay medication initiation and establish workflows that support timely treatment when patients are ready.
- **Strong operational systems support safe field-based care.** Clear policies for medication procurement, storage, transportation, administration, and inventory management are essential to maintaining safety, compliance, and accountability in community settings.
- **MAT initiation is only the beginning.** Ongoing monitoring, follow-up, care coordination, and retention support are critical to helping patients achieve their treatment goals and maintain engagement over time.
- **MAT and other medication approaches vary by substance, but the principles remain the same.** Regardless of the substance involved, treatment should be individualized, evidence-based, regularly reassessed, and integrated into broader recovery supports.
- **Withdrawal management should serve as a bridge to ongoing treatment.** Encounters involving withdrawal present important opportunities to initiate medications, strengthen engagement, and connect individuals to longer-term recovery services.
- **Collaboration is essential to successful implementation.** Effective field-based medication services rely on strong partnerships with pharmacies, prescribers, opioid treatment programs, payers, behavioral health providers, and other community partners.

IF YOU ARE READY TO…	GO TO…

Select medications for alcohol use disorder	>	**Tool 7.A**	Medications for Alcohol Use Disorder Quick Reference Guide
Assess and manage alcohol withdrawal safely	>	**Tool 7.B**	Alcohol Withdrawal Management Quick Reference Guide
Support patients with nicotine or tobacco cessation medications	>	**Tool 7.C**	Medications for Nicotine/Tobacco Use Disorder Quick Reference Guide
Select and prescribe medications for opioid use disorder	>	**Tool 7.D**	Medications for Opioid Use Disorder Quick Reference Guide
Initiate buprenorphine treatment in the field or clinic setting	>	**Tool 7.E**	Buprenorphine Initiation Checklist
Compare medication treatment options across SUDs	>	**Tool 7.F**	Pharmacologic Treatment for SUD

REFERENCES

Adams, K. K., Waters, K., & Sobieraj, D. M. (2025). Initiating buprenorphine to treat opioid use disorder without prerequisite withdrawal: An updated systematic review. *Addiction Science & Clinical Practice, 20*(1), 19. https://doi.org/10.1186/s13722-025-00548-z

American Society of Addiction Medicine. (2023). *Alcohol use disorder resource guide*. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/education-docs/aud-resource-guide-2023.pdf

American Society of Addiction Medicine. (2020). *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*. *Journal of Addiction Medicine, 14*(3S Suppl. 1), 1–72. https://doi.org/10.1097/ADM.0000000000000668

American Society of Addiction Medicine, & American Academy of Addiction Psychiatry. (2024). *The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder*. *Journal of Addiction Medicine, 18*(1), 1–56. https://doi.org/10.1097/ADM.0000000000001299

Berk, J., Rose, M., & Thakrar, A. P. (2025). Low-dose initiations of buprenorphine in the fentanyl era—A search for evidence-based approaches to an evolving crisis. *JAMA Network Open, 8*(1), e2456261. https://doi.org/10.1001/jamanetworkopen.2024.56261

Centers for Disease Control and Prevention. (2024, September 17). *Cigarette smoking*. https://www.cdc.gov/tobacco/about/index.html

Cohen, S. M., Weimer, M. B., Levander, X. A., Peckham, A. M., Tetrault, J. M., & Morford, K. L. (2022). Low dose initiation of buprenorphine: A narrative review and practical approach. *Journal of Addiction Medicine, 16*(4), 399–406. https://doi.org/10.1097/ADM.0000000000000945

D'Onofrio, G., Herring, A. A., Perrone, J., Hawk, K., Englander, H., Snyder, H., Krawczyk, N., Schottenfeld, R. S., Fiellin, D. A., & Chawarski, M. C. (2024). Extended-release 7-day injectable buprenorphine for patients with minimal to mild opioid withdrawal. *JAMA Network Open, 7*(7), e2420702. https://doi.org/10.1001/jamanetworkopen.2024.20702

Gentzke, A. S., Wang, T. W., Cornelius, M., et al. (2024). Tobacco product use among middle and high school students—National Youth Tobacco Survey, United States, 2024. *Morbidity and Mortality Weekly Report, 73*(41), 917–924. https://doi.org/10.15585/mmwr.mm7341a2

Giulietti, F., Filipponi, A., Rosettani, G., Giordano, P., Iacoacci, C., Spannella, F., & Sarzani, R. (2020). Pharmacological approach to smoking cessation: An updated review for daily clinical practice. *High Blood Pressure & Cardiovascular Prevention, 27*(5), 349–362. https://doi.org/10.1007/s40292-020-00396-9

Handelsman, L., Cochrane, K. J., Aronson, M. J., Ness, R., Rubinstein, K. J., & Kanof, P. D. (1987). Two new rating scales for opiate withdrawal. *The American Journal of Drug and Alcohol Abuse, 13*(3), 293–308. https://doi.org/10.3109/00952998709001515

Hervera, B., Seo, G., Bartholomew, T. S., Chueng, T. A., Suarez, E., Forrest, D. W., Hernandez, S., Rodriguez, A. E., Tookes, H. E., Doblecki-Lewis, S., & Serota, D. P. (2023). *Implementation of an integrated infectious disease and substance use disorder team for injection drug use-associated infections: A qualitative study*. *Addiction Science & Clinical Practice, 18*(8). https://doi.org/10.1186/s13722-023-00363-4

Holt, S. R., Saxon, A. J., Swenson, S., & Friedman, M. (2026, March 24). *Alcohol use disorder: Pharmacologic management*. In *UpToDate*. Wolters Kluwer. Retrieved May 18, 2026, from https://www.uptodate.com

Holt, S. R., & Tetrault, J. M. (2024, October 23). *Alcohol withdrawal: Ambulatory management*. In *UpToDate*. Wolters Kluwer. Retrieved May 18, 2026, from https://www.uptodate.com

Janssen-Aguilar, R., Meshkat, S., Demchenko, I., Zhang, Y., Greenshaw, A., Dunn, W., … Bhat, V. (2025). Role of ketamine in the treatment of substance use disorders: A systematic review. *Journal of Substance Use and Addiction Treatment, 175*, 209705. https://doi.org/10.1016/j.josat.2025.209705

Kumar, R., Viswanath, O., & Saadabadi, A. (2024, June 8). *Buprenorphine*. In *StatPearls*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK459126/

Leach, M., Marziali, M. E., Parashar, S., Bondy, G., Guillemi, S., Harris, M., Hull, M., Stone, S., Kooij, K. W., Hogg, R. S., & Montaner, J. S. G. (2026). A rapid review of the effects of GLP-1 receptor agonists on opioid and stimulant use-related outcomes. *Drug and Alcohol Dependence Reports, 19*, 100440. https://doi.org/10.1016/j.dadr.2026.100440

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and young adults' use and perceptions of pod-based electronic cigarettes. *JAMA Network Open, 1*(6), e183535. https://doi.org/10.1001/jamanetworkopen.2018.3535

McPheeters, M., O'Connor, E. A., Riley, S., Kennedy, S. M., Voisin, C., Kuznacic, K., Coffey, C. P., Edlund, M. D., Bobashev, G., & Jonas, D. E. (2023). Pharmacotherapy for alcohol use disorder: A systematic review and meta-analysis. *JAMA, 330*(17), 1653–1665. https://doi.org/10.1001/jama.2023.19761

Mooney, L. (2022). *Pharmacotherapy for alcohol use disorder* [Educational presentation]. Providers Clinical Support System (PCSS). https://education.sudtraining.org/Public/Catalog/Details.aspx?id=wfdYvbHRaCndv5aFs9ydnQ%3D%3D

National Institute on Drug Abuse. (n.d.). *NIDA-modified Alcohol, Smoking, and Substance Involvement Screening Test (NM ASSIST).* U.S. Department of Health and Human Services, National Institutes of Health. https://nida.nih.gov/sites/default/files/pdf/nmassist.pdf

Parks, M. J., Blanco, C., Creamer, M. R., Goodwin, R. D., Hasin, D. S., Martins, S. S., & Weinberger, A. H. (2025). Cigarette smoking during recovery from substance use disorders. *JAMA Psychiatry, 82*(10), 1002–1008. https://doi.org/10.1001/jamapsychiatry.2025.1976

Rigotti, N. A. (2025, May 16). *Pharmacotherapy for smoking cessation in adults*. In *UpToDate*. Wolters Kluwer. Retrieved May 15, 2026, from https://www.uptodate.com

Rigotti, N. A., Kruse, G. R., Livingstone-Banks, J., & Hartmann-Boyce, J. (2022). Treatment of tobacco smoking: A review. *JAMA, 327*(6), 566–577. https://doi.org/10.1001/jama.2022.0395

Ronsley, C., Nolan, S., Knight, R., Hayashi, K., Klimas, J., Walley, A., Wood, E., & Fairbairn, N. (2020). Treatment of stimulant use disorder: A systematic review of reviews. *PLOS ONE, 15*(6), e0234809. https://doi.org/10.1371/journal.pone.0234809

Rosenwohl-Mack, S., Suen, L. W., Logan, A. A., Peterson, D., & Snyder, H. R. (2025). Outpatient initiation of 7-day injectable buprenorphine: A direct-to-inject case series. *Journal of Substance Use and Addiction Treatment, 46*(4), 1064–1069. https://doi.org/10.1177/29767342251330412

Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption—II. *Addiction, 88*(6), 791–804. https://doi.org/10.1111/j.1360-0443.1993.tb02093.x

Snyder, H., Chau, B., Kalmin, M. M., Speener, M., Campbell, A., Moulin, A., & Herring, A. A. (2023). High-dose buprenorphine initiation in the emergency department among patients using fentanyl and other opioids. *JAMA Network Open, 6*(3), e231572. https://doi.org/10.1001/jamanetworkopen.2023.1572

Substance Abuse and Mental Health Services Administration. (2021). *Medications for opioid use disorder* (Treatment Improvement Protocol [TIP] Series 63; Publication No. PEP21-02-01-

002). U.S. Department of Health and Human Services. https://store.samhsa.gov/product/pep21-02-01-002

Suen, L. W., Lee, T. G., Silva, M., Walton, P., Coffin, P. O., Geier, M., & Soran, C. S. (2022). Rapid overlap initiation protocol using low dose buprenorphine for opioid use disorder treatment in an outpatient setting: A case series. *Journal of Addiction Medicine, 16*(5), 534–540. https://doi.org/10.1097/ADM.0000000000000961

Thakrar, A. P., Christine, P. J., Siaw-Asamoah, A., Krawczyk, N., Fong, J., Saloner, B., & Wakeman, S. E. (2024). Buprenorphine-precipitated withdrawal among hospitalized patients using fentanyl. *JAMA Network Open, 7*(9), e2435895. https://doi.org/10.1001/jamanetworkopen.2024.35895

Tiglao, S. M., Meisenheimer, E. S., & Oh, R. C. (2021). Alcohol withdrawal syndrome: Outpatient management. *American Family Physician, 104*(3), 253–262. https://www.aafp.org/pubs/afp/issues/2021/0900/p253.html

Weimer, M. B., Herring, A. A., Kawasaki, S. S., Meyer, M., Kleykamp, B. A., & Ramsey, K. S. (2023). ASAM clinical considerations: Buprenorphine treatment of opioid use disorder for individuals using high-potency synthetic opioids. *Journal of Addiction Medicine, 17*(6), 632–639. https://doi.org/10.1097/ADM.0000000000001170

SECTION 8:
FINANCING AND SUSTAINABILITY

PURPOSE

This section provides a high-level overview of resources available to California Behavioral Health Departments to support their efforts in financing and sustaining the Assertive Filed-based SUD Treatment and Services required by the Behavioral Health Services Act (BHSA). A detailed description of approaches to financing and accountability are beyond the scope of this toolkit and have been addressed in more detail by the two organizations which resources are referenced below.

HOW TO USE THIS SECTION

This section outlines **approaches for financing, sustaining, and expanding AFBSS programs over time**. As you review the content, consider:

- ☑ What funding sources currently support your services?
- ☑ What resources are needed to sustain implementation over time?
- ☑ How can financing strategies support future growth and expansion?

Throughout this section, you'll find financing considerations, sustainability strategies, and planning resources. These tools can help you **identify funding opportunities, align resources, and support long-term program success**.

FINANCING AND SUSTAINABILITY LANDSCAPE FOR ASSERTIVE FIELD-BASED SUD TREATMENT AND SERVICES

A ASSERTIVE FIELD-BASED SUBSTANCE USE DISORDER SERVICES (AFBSS) FINANCING OVERVIEW

Assertive Field-Based Substance Use Disorder Services (AFBSS) is a complex set of services that is evolving and for which multiple financing pathways may be required to support eligible activities.

AFBSS includes both billable clinical services, and non-clinical activities such as outreach, engagement and support services, each of which should be mapped to potential funding sources (e.g., Medi-Cal, BHSA, etc.) to leverage reimbursement sources and optimize financing.

Financing of AFBSS requires creative, braided financing approaches that leverage or build on existing programs.

CONSIDER THIS

Many programs find that diversified funding approaches provide greater flexibility and reduce vulnerability when funding priorities, grant opportunities, or reimbursement policies change.

Instead of: Reling on a single funding source to support long-term program operations.

Try this: Develop a financing strategy that leverages multiple funding streams and evolves as program needs change.

FUNDING STREAMS TO CONSIDER FOR AFBSS

- Behavioral Health Services Act (BHSA) County Policy Manual – for programmatic activities included in the three-year Integrated Plan and in-scope for BHSA components (AFBSS).
- Local realignment dollars and county general funds may be used as well as local non-federal share or inter-governmental transfer (IGT)-supported financing to match federal dollars.
- Medi-Cal Administrative Activity dollars (for allowable Medi-Cal administrative functions).
- Medi-Cal patient care revenue.
- Opioid Settlement Funds.
- Other (non-Medi-Cal) insurance payments, as available.
- Substance Use Prevention Block Grant (SUBG) dollars, subject to federal and DHCS rules.

FINANCING AND SUSTAINABILITY RESOURCES AVAILABLE TO BEHAVIORAL HEALTH DEPARTMENTS

The state Department of Health Care Services contracted with two organizations in an effort to support Behavioral Health Departments in their work to finance and sustain activities in their BHSA integrated plans. Those include the California Mental Health Services Authority (CalMHSA) and the Boston Consulting Group (BCG). Each of these contractors addressed a distinct aspect of financing.

OPTIMIZING FEDERAL MATCHING DOLLARS FOR BHSA

Training and technical assistance (TTA) is available from the Boston Consulting Group (BCG).

Seventeen educational modules are available covering the following topics:

- Billable service capture.
- Providers: eligibility, productivity, supervision.
- Fiscal and data performance management.
- Billable service design: new client engagement and new billing peer pathways.

TTA on optimizing federal matching dollars can be accessed by enrolled BH Department staff at the **DHCS County Portal Support Center**.

FISCAL PLANNING AND COMPLIANCE: ESSENTIAL KNOWLEDGE FOR BEHAVIORAL HEALTH DEPARTMENT LEADERS

As a statewide joint powers authority, CalMHSA develops strategies and programs that support county (and municipal) Behavioral Health Departments in improving behavioral health for all Californians.

The Behavioral Health Fiscal Academy (BHFA) provides a clear framework for understanding behavioral health funding streams, reimbursement methodologies, forecasting strategies, and key regulatory obligations in a structured, nine-module training program designed for county behavioral health finance professionals who are new or at an intermediate level.

RESOURCES

The resources below provide practical tools, training materials, technical assistance, and implementation guidance to help counties identify funding opportunities, optimize reimbursement, strengthen fiscal management, and support long-term sustainability of AFBSS programs.

SECTION 8 KEY TAKEAWAYS & RESOURCE MAP

REFERENCES

California Department of Health Care Services. (2026). *Behavioral Health Services Act (BHSA) policy manual*. https://policy-manual.mes.dhcs.ca.gov/

GLOSSARY

Acuity	The level of complexity, risk, and service intensity associated with an individual's needs. Acuity helps determine staffing requirements, frequency of contact, caseload size, and the amount of team involvement needed to provide effective care.
Assertive Community Treatment (ACT)	An evidence-based practice to support individuals living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services.
Assertive Engagement	A proactive, person-centered approach to connecting with individuals who may have significant barriers to care. Assertive engagement emphasizes persistence, relationship building, trust, and ongoing outreach to support participation in services and treatment.
Assertive Field-Based Substance Use Disorder Services (AFBSS)	A proactive, field-based approach to engaging individuals with substance use disorder who are not connected to care. AFBSS brings outreach, treatment initiation, care coordination, and recovery support directly to people in community settings and emphasizes rapid access to treatment through a “no-wrong door” approach.
Care Coordination	The deliberate organization and management of services across providers, programs, and systems to ensure individuals receive timely, comprehensive, and connected care.
Care Transition	The movement of an individual from one care setting, provider, or level of care to another. Effective care transitions support continuity of services and reduce disruptions in treatment and recovery.
Caseload	The number of individuals assigned to a staff member or team for ongoing services. In AFBSS, caseloads should reflect individual acuity, service intensity, and team capacity rather than traditional productivity expectations.

Closed-Loop Referral	A referral process in which the referring organization actively tracks the referral, confirms whether services were received, and receives feedback on the outcome. The goal is to ensure successful connection to care rather than simply making a referral.
Community-Based Organization (CBO)	A public, nonprofit, tribal, faith-based, or community organization that provides services, supports, advocacy, or resources to individuals and communities.
Community-Based Outreach	Outreach activities designed to engage groups, communities, or locations identified as having elevated risk of overdose or limited access to services. Community-based outreach focuses on reaching people where they live, gather, or spend time.
Contingency Management (CM)	An evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests that are negative for stimulants.
Continuity of Care	The consistent coordination and delivery of services over time and across settings to support ongoing engagement, treatment, recovery, and successful transitions between levels of care.
Co-Occurring Conditions	The presence of a substance use disorder and one or more mental health and/or physical health conditions occurring at the same time. Effective treatment typically involves coordinated, integrated care that addresses all conditions together.
Data-Informed Outreach	An outreach approach that uses data, community knowledge, and lived experience to identify priority populations, guide outreach strategies, and improve engagement with individuals who may be at elevated risk of overdose or unmet treatment needs.
Enhanced Care Management (ECM)	Whole-person, interdisciplinary approach to care that addressed the clinical and non-clinical needs of Medi-Cal Members with the most complex and social needs. ECM provides systematic coordination of

	services and comprehensive care management that is community based, interdisciplinary, high tough and person centered.
Fidelity	The degree to which a program, intervention, or service model is implemented as intended. Fidelity helps ensure that evidence-based practices are delivered consistently and effectively.
Forensic Assertive Community Treatment (FACT)	Builds upon the Assertive Community Treatment (ACT) model to address the complex needs of individuals with significant behavioral health needs who are also involved with the criminal justice system.
Harm Reduction	A practical, person-centered approach that seeks to reduce the negative health, social, and safety consequences associated with substance use without requiring abstinence as a condition of receiving services.
Hot Spot	A geographic spot on a map where multiple overdoses have occurred in a specified amount of time.
Individual-Based Outreach	Direct, person to person engagement with someone at risk of drug overdose.
Low-Barrier Access	A service design approach that minimizes obstacles such as appointments, paperwork, transportation requirements, sobriety expectations, or other conditions that may prevent individuals from accessing care.
Medications for Addiction Treatment (MAT)	The use of medications, often in combination with counseling and supportive services, to treat substance use disorders and reduce the risk of overdose and other negative outcomes.
Medications for Opioid Use Disorder (MOUD)	Medications approved to treat opioid use disorder, including buprenorphine, methadone, and naltrexone. MOUD is considered the standard of care for opioid use disorder.
Memorandum of Understanding (MOU)	A formal written agreement between two or more organizations that defines their shared goals, roles, responsibilities, and expectations for collaboration and coordination.

Mobile Field-Based Program	A core component of Assertive Field-Based Substance Use Disorder Services (AFBSS) in which mobile teams provide on-the-ground engagement, trust-building, harm reduction support, and direct provision of, or rapid referral and linkage to, substance use disorder treatment and medications for addiction treatment (MAT) in community settings.
Motivational Interviewing (MI)	A counseling approach designed to help individuals resolve ambivalence about their alcohol and/or drug use, and supports efforts to change it. MI is often delivered as a brief intervention based on client-centered principles.
Multidisciplinary Team	A group of professionals from different disciplines who work together to address an individual's medical, behavioral health, social, and recovery needs through a coordinated approach to care.
Open-Access Clinic	A low-barrier outpatient service model that provides rapid or same-day access to treatment and support services with minimal administrative, scheduling, or eligibility barriers.
Outreach	In the context of AFBSS, outreach is community-based with the goal of connecting more individuals with services that meet their immediate basic needs and long-term needs for treatment, rather than engagement of people already enrolled in care.
Peer Support Specialist	An individual with lived experience of substance use, mental health challenges, or recovery who is trained to provide support, mentorship, advocacy, and connection to services for others. Peer support specialists are integral members of AFBSS teams.
Priority Population	Groups experiencing elevated risk of overdose or lower access to services based on current data and lived experience.
Psychological Safety	A team environment in which individuals feel comfortable asking questions, sharing concerns, reporting mistakes, seeking help, and offering ideas without fear of blame, embarrassment, or retaliation.

Recovery-Oriented Care	A person-centered approach that supports individuals in defining and pursuing their own recovery goals while building on strengths, hope, self-determination, and community connection.
Reflective Supervision	A relationship-based supervision approach that provides staff with a structured opportunity to explore experiences, reactions, and challenges encountered in their work. Reflective supervision supports self-awareness, resilience, and relationship-centered care.
Shared Caseload	A service delivery model in which the entire team shares responsibility for a group of individuals rather than assigning each person to a single staff member. This approach improves continuity, flexibility, and access to care.
Syndromic Data	Near real-time health data used to identify emerging patterns or events, such as overdose spikes or increases in substance-related emergencies, and guide timely public health and outreach responses.
Team-Based Care	A care delivery approach in which professionals from different disciplines work together with individuals receiving services to provide coordinated, person-centered care. Team members share responsibility for outcomes and collaborate in planning, decision-making, and service delivery.
Team Huddle	A brief, structured team meeting used to review priorities, coordinate services, identify high-risk situations, and align responsibilities for the day or shift ahead.
TeamSTEPPS®	An evidence-based framework designed to improve teamwork, communication, leadership, situation monitoring, and mutual support. TeamSTEPPS provides practical tools such as huddles, debriefs, and structured communication techniques to improve team performance and safety.
Trauma-Informed Care	An approach to care that recognizes the widespread impact of trauma and incorporates practices that promote safety, trust, empowerment, collaboration, and cultural responsiveness while avoiding re-traumatization.

ACRONYMS

AAAP	American Academy of Addiction Psychiatry
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
ADT	Admission, Discharge, and Transfer
AFBSS	Assertive Field-Based Substance Use Disorder Services
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
AUDIT	Alcohol Use Disorder Identification Test
AWS	Alcohol Withdrawal Syndrome
BCG	Boston Consulting Group
BHFA	Behavioral Health Fiscal Academy
BHSA	Behavioral Health Services Act
CalHHS	California Health and Human Services Agency
CalMHSA	California Mental Health Services Authority
CBO	Community Based Organization
CBT	Cognitive Behavioral Therapy
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CHW	Community Health Worker
CIWA-AR	Clinical Institute Withdrawal Assessment for Alcohol-Revised
CLR	Closed-Loop Referral
CM	Contingency Management
CMS	Centers for Medicare & Medicaid Services
CoC	Continuum of Care
COPD	Chronic Obstructive Pulmonary Disease

COPE	Connecting Overdose Prevention Efforts
COWS	Clinical Opiate Withdrawal Scale
CPR	Cardiopulmonary Resuscitation
CPS	Child Protective Services
CSS	Community Services and Supports
CUS	Concerned, Uncomfortable, Safety
DEA	Drug Enforcement Administration
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EBP	Evidence Based Practices
ECM	Enhanced Care Management
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
EOP	Engagement and Overdose Prevention
FACT	Forensic Assertive Community Treatment
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
FSP	Full Service Partnerships
GAD-7	Generalized Anxiety Disorder 7-item scale
GLP-1	Glucagon-like Peptide-1
HEDIS	Healthcare Effectiveness Data and Information Set
HIDTA	High Intensity Drug Trafficking Area
IGT	Intergovernmental Transfer
LAI	Long-Acting Injectable
LCM	Lead Care Manager
LCSW	Licensed Clinical Social Worker

LEC-5	Life Event Checklist
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and other sexual and gender identities
LMFT	Licensed Marriage and Family Therapist
LOU	Letter of Understanding
LPCC	Licensed Professional Clinical Counselor
LVN	Licensed Vocational Nurse
MAT	Medications for Addiction Treatment
MAUD	Medications for Alcohol Use Disorder
MCP	Managed Care Plan
MINI	MINI International Neuropsychiatric Interview
MOUD	Medications for Opioid Use Disorder
MOU	Memorandum of Understanding
NCCC	National Clinician Consultation Center
NDRI	Norepinephrine and Dopamine Reuptake Inhibitor
NMDA	N-methyl-D-aspartate
NRT	Nicotine Replacement Therapy
NP	Nurse Practitioner
NTP	Narcotic Treatment Program
ODMAP	Overdose Detection Mapping Application Program
OPI	Overdose Prevention Initiative
OTOD	Opioid Treatment on Demand
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PA	Physician Assistant
PDMP	Prescription Drug Monitoring Program
PCP	Primary Care Provider
PDSA	Plan-Do-Study-Act
PHQ-9	Patient Health Questionnaire-9
PSS	Peer Support Specialist

PRAPARE	Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences
PTSD	Post-Traumatic Stress Disorder
PWUD/PWUO	People who use drugs/opioids
RHC	Rural Health Clinic
RN	Registered Nurse
SAMSHA	Substance Abuse and Mental Health Administration Services
SBAR	Situation, Background, Assessment, and Recommendation
SDOH	Social Determinants of Health
SMART	Specific, Measurable, Achievable, Relevant, and Time-bound
SMI	Serious Mental Illness
SOWS	Subjective Opiate Withdrawal Scale
SSP	Syringe Services Program
STI	Sexually Transmitted Infection
StUD	Stimulant Use Disorder
SUD	Substance Use Disorder
TAPS	Tobacco, Alcohol, Prescription Medication and Other Substances Use (TAPS)
TAY	Transitional Age Youth
TEAMSTEPPS®	Team Strategies and Tools to Enhance Performance and Patient Safety
TTA	Training and Technical Assistance
UCSF	University of California, San Francisco
USC	University of Southern California
VA	Department of Veterans Affairs
WET	Workforce Education and Training
WHO	World Health Organization

AFBSS TOOLS AND RESOURCES

The resources included in this section are referenced throughout the toolkit and are intended to support implementation in real-world settings. They include worksheets, templates, checklists, planning tools, and other practical resources that can help organizations translate AFBSS concepts into action.

Whether you are launching a new initiative, strengthening existing services, or refining specific components of your approach, these resources can be used to support planning, decision-making, stakeholder engagement, quality improvement, and ongoing implementation efforts.

TOOL 1.A: AFBSS COMPONENT MAPPING WORKSHEET

Designed For: Inventorying existing programs, services, partnerships, and infrastructure.

How to Use: Document current activities to identify strengths, gaps, and opportunities for enhancement.

Recommended Users: County planners, program managers, behavioral health leaders, implementation teams, and system partners.

Assertive, Field-Based Engagement
Describe existing programs, services or partnerships: Strengths to build on: Gaps or Opportunities:
No Wrong Door Access
Describe existing programs, services or partnerships: Strengths to build on: Gaps or opportunities:

Voluntary, Person-Centered Care
Describe existing programs, services or partnerships: Strengths to build on: Gaps or opportunities:
Rapid Initiation of Treatment
Describe existing programs, services or partnerships: Strengths to build on: Gaps or opportunities:
Integrated and Coordinated Systems
Describe existing programs, services or partnerships: Strengths to build on: Gaps or opportunities:

Equity-Driven Design
Describe existing programs, services or partnerships: Strengths to build on: Gaps or opportunities:

Discussion Questions

Discuss the following as a group.

- What AFBSS-related services already exist?
- Where are services disconnected, duplicative, or difficult to access?
- What current assets or strengths can we build upon? Which gaps are most important to address first?
- Which existing programs could be expanded or strengthened rather than rebuilt? What potential partnerships could we explore?

TOOL 1.B: AFBSS IMPLEMENTATION PRIORITIES WORKSHEET

Designed For: Implementation planning, strategic discussions, and readiness assessment.

How to Use: Identify opportunities for improvement, prioritize action items, and establish ownership for implementation activities.

Recommended Users: Leadership teams, implementation committees, BHSA planning teams, and program supervisors.

Opportunity or Need	Why It Matters	Priority	Owner

PRIORITY AREAS TO CONSIDER

- Identifying target populations
- Expanding mobile field-based services
- Improving referral pathways
- Strengthening community partnerships
- Building cross-system coordination
- Strengthening data-informed outreach
- Increasing access to MAT
- Enhancing peer support integration
- Improving equity and access
- Workforce development and training

DISCUSSION QUESTIONS

- Which opportunity would have the greatest impact on treatment access?
- Which activities can be strengthened using existing resources?
- Which priorities require new partnerships or infrastructure?
- What should be accomplished first to create momentum for implementation?

TOP THREE PRIORITIES

1.

2.

3.

TOOL 2.A: SUBSTANCE USE DISORDER (SUD) SCREENING TOOL REFERENCE GUIDE

Designed For: AFBSS teams, clinicians, peers, care coordinators, supervisors, and outreach staff.

How to Use: Use screening tools to identify potential concerns related to substance use, mental health, physical health, and social needs. Positive screens should be followed by additional assessment, care planning, referral, or treatment as appropriate.

Recommended Users: Outreach workers, peer specialists, SUD counselors, behavioral health clinicians, nurses, prescribers, care coordinators, and multidisciplinary care teams.

SUBSTANCE USE

Tool	Purpose	Administration
AUDIT (Alcohol Use Disorders Identification Test) (website | tool)	Screens for hazardous or harmful alcohol use.	10-item questionnaire. May be self-administered or completed with a team member.
AUDIT-C (website | tool)	Brief screen for risky alcohol use based on frequency and quantity of drinking.	First three questions of AUDIT. May be self-administered or completed by staff.
TAPS (Tobacco, Alcohol, Prescription Medication and Other Substance Use) (website | tool)	Screens for tobacco, alcohol, prescription medication misuse, and other drug use.	Two-part screening tool. Positive responses in Part 1 trigger additional questions in Part 2.
NIDA Quick Screen and NIDA Modified Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) (**website** | **tool**)	Screens for tobacco, alcohol, illicit drug use, and nonmedical use of prescription medications; identifies risky substance use and helps determine the need for brief intervention or referral treatment.	Two-step screening process. Begins with the brief NIDA Quick Screen. Patients who report illicit drug use or nonmedical use of prescription medications complete the NIDA-Modified ASSIST, which includes follow-up questions to assess level of risk.

MENTAL HEALTH

Tool	Purpose	Administration
PHQ-9 (Patient Health Questionnaire-9) (website | tool)	Screens for depression symptoms and suicide risk.	9-item self-administered questionnaire assessing symptoms over the previous two weeks.
GAD-7 (Generalized Anxiety Disorder-7) (website | tool)	Screens for anxiety symptoms.	7-item self-administered questionnaire assessing symptoms over the previous two weeks.
PC-PTSD-5 (Primary Care PTSD Screen for DSM-5) (website | tool)	Screens for probable post-traumatic stress disorder (PTSD).	Begins with a trauma exposure question followed by five yes/no symptom questions if trauma is endorsed.
LEC-5 (Life Events Checklist for DSM-5) (website | tool)	Identifies exposure to potentially traumatic events.	Self-report checklist documenting exposure to a range of potentially traumatic experiences.
PEARLS (Pediatric ACEs and Related Life Events Screener) (website | tools)	Screens for adverse childhood experiences (ACEs) and related adversities.	Available in age-specific versions for children, adolescents, and caregivers.

SOCIAL NEEDS

Tool	Purpose	Administration
PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) (website | tool)	Identifies social risks and strengths related to housing, employment, transportation, social support, and other SDOH.	Standardized questionnaire completed with the individual during screening or assessment.
HOUSED BEDS (Homeless history, Outreach engagement, Utilization, Salary/income, Eat, Drink, Bathroom, Encampment, Daily routine, Substance use) (resource)	Assesses barriers commonly experienced by individuals experiencing homelessness or unsheltered homelessness.	Structured interview using questions related to homelessness, resource access, basic needs, daily living, and substance use.

Tool	Purpose	Administration
AHC-HRSN (Accountable Health Communities Health-Related Social Needs Screening Tool) (guide | tool)	Identifies unmet health-related social needs that may affect health outcomes and engagement.	Standardized screening tool assessing housing, food security, transportation, utilities, and interpersonal safety.

TOOL 2.B: AFBSS ACUITY CONSIDERATIONS TOOL

Designed For: AFBSS teams balancing shared caseloads, staffing capacity, outreach intensity, and multidisciplinary support.

How to Use: Review the team's caseload during huddles, case conferences, or workload-planning meetings. Consider each individual's acuity across the domains below, then examine the overall mix of lower-, moderate-, high-, and very-high-acuity clients distributed across the team. Use the discussion to redistribute work, adjust outreach and follow-up, involve additional disciplines, and identify when the team may not have sufficient capacity to safely support additional clients.

Recommended Users: Supervisors, program managers, outreach workers, peer support specialists, SUD counselors, nurses, prescribers, care coordinators, and multidisciplinary care teams.

USING ACUITY TO BALANCE TEAM CAPACITY

Especially while providing AFBSS, caseload size alone should not determine workload. Two teams serving the same number of individuals may require very different levels of staffing and support depending on the mix of acuity, outreach needs, care coordination demands, and environmental barriers involved.

Higher-acuity caseloads generally require:

- More frequent outreach and field-based contact.
- Greater multidisciplinary involvement.
- More care coordination across providers and systems.
- Additional transportation, accompaniment, and follow-up.
- More frequent case review and reassessment.
- Increased crisis planning and safety support.
- More time for relationship-building and re-engagement.
- Greater documentation and communication demands.

Teams should review acuity collectively rather than relying only on individual caseload assignments. The goal is to ensure that the overall distribution of needs is manageable and that staff have enough time and support to provide responsive care without creating unsustainable workloads, fatigue, or burnout.

ACUITY CONSIDERATIONS

When reviewing an individual's expected level of support and work effort, consider the following domains:

Acuity Domain	Considerations for Caseload Planning
Medical Complexity and Health Risk	Chronic or unstable medical conditions, wound care, medication barriers, mobility needs, pregnancy, recent hospitalization, or frequent emergency department use
Field-Based Care Intensity	Difficulty locating the individual, travel demands, frequent outreach attempts, appointment accompaniment, medication delivery, or need for multiple staff during visits
Substance Use and Overdose Risk	Recent overdose, severe withdrawal risk, fentanyl exposure, polysubstance use, injection drug use, or limited connection to treatment and harm reduction services
Behavioral Health and Safety Risk	Acute psychiatric symptoms, suicidality, psychosis, emotional instability, or safety concerns affecting engagement and service delivery
Housing and Environmental Instability	Unsheltered homelessness, displacement, unsafe environments, limited food or water, lack of medication storage, or loss of communication access
Engagement and Follow-Through	Difficulty maintaining contact, repeated disengagement, mistrust of systems, cognitive barriers, or need for persistent motivational engagement
Crisis and System Involvement	Recent hospitalization, crisis response, detoxification, incarceration, frequent EMS use, or repeated transitions between systems
Care Coordination Complexity	Multiple providers or agencies, housing and benefits needs, legal involvement, specialty care, or frequent multidisciplinary coordination

DESCRIBING RELATIVE ACUITY

Rather than generating a precise numerical score, teams may assign a **relative acuity level** based on the combined intensity of needs across the domains.

Relative Acuity	General Description	Potential Team Response
Lower / Stabilizing	Needs are present but comparatively stable and manageable with routine support.	Maintain planned outreach, care coordination, and periodic reassessment.
Moderate	Multiple active needs or barriers require regular outreach and coordinated follow-up.	Increase coordination and multidisciplinary involvement as needed.
High	Significant instability requires frequent outreach, active coordination, and regular team review.	Prioritize shared case review, proactive follow-up, and coordinated team involvement.
Very High / Urgent	Immediate or intensive medical, behavioral health, safety, housing, or system-level needs are present.	Provide rapid multidisciplinary response, frequent reassessment, safety planning, and intensive field-based support.

An urgent concern should prompt immediate team review regardless of the individual's overall acuity designation. Examples include a recent overdose, severe withdrawal risk, active suicidality, acute psychosis, an untreated serious medical condition, pregnancy with significant instability, or an immediate threat to safety.

REVIEWING THE TEAM'S ACUITY MIX

During caseload review, teams should consider:

- How many individuals currently require high or very-high-intensity support?
- Which individuals require multiple contacts or staff members each week?
- Where is substantial travel, outreach, or accompaniment required?
- Which cases involve intensive cross-system coordination?

- Are high-acuity individuals concentrated among particular staff members?
- Does the team have adequate clinical, peer, nursing, and care coordination capacity?
- Which responsibilities can be redistributed across the shared caseload?
- Are any staff members carrying workloads that are no longer sustainable?
- Does the team need to adjust intake, coverage, scheduling, or partnership support?

CASELOAD-BALANCING DECISIONS

A balanced caseload is not necessarily an equal caseload. One staff member may support fewer individuals because those individuals require more frequent outreach, travel, coordination, or multidisciplinary involvement. Caseload decisions should reflect actual work effort and the overall acuity mix, not client counts alone.

Based on the review, the team may:

- Redistribute primary and backup responsibilities.
- Adjust outreach frequency and contact plans.
- Add clinical, peer, nursing, or care coordination support.
- Group field visits geographically to reduce travel demands.
- Reassign administrative or coordination tasks.
- Increase case review or supervision.
- Step down service intensity when needs stabilize.
- Reconsider new assignments when team capacity is insufficient.
- Seek additional staffing, partner support, or program resources.

Team Huddle Questions

- What is driving the individual's current level of need?
- What support is required this week?
- Which disciplines should be involved?
- How much outreach, travel, coordination, and follow-up will be required?
- Is the current workload sustainable?
- Should responsibilities or resources be redistributed?

TOOL 3.A: APPLYING AN EQUITY LENS TO DATA-INFORMED OUTREACH

Designed For: Periodic equity-focused discussions, data review meetings, outreach planning sessions, quality improvement activities, and cross-system partner conversations.

How to Use: While equity should be integrated into everyday planning and decision-making, this tool can help teams periodically take a deeper look at strengths, gaps, and opportunities. Use this worksheet to examine outreach data through an equity lens, identify populations or communities that may be underrepresented or underserved, and explore opportunities to strengthen how data, lived experience, and community knowledge inform outreach decisions.

Recommended Users: Outreach staff, peers and people with lived experience, program supervisors, quality improvement staff, data analysts, behavioral health leaders, and community or system partners involved in outreach planning and decision-making.

WHO IS VISIBLE IN THE DATA?

Use this section to review which populations, neighborhoods, or groups are most visible in available data sources.

Which populations appear most frequently in outreach, overdose, surveillance, or service utilization data?	
Which neighborhoods, settings, or locations appear most often?	
Which groups appear to be accessing services or engaging with outreach most consistently?	
What strengths or successful practices may be contributing to this visibility or engagement?	

WHO MAY BE MISSING?

Use this section to consider who may be experiencing risk but may not be fully represented in the data.

Which populations may be less visible or absent from available data?	
Are there communities that outreach teams, peers, or partners are concerned about that do not appear strongly in the data?	
Are certain neighborhoods, languages, cultural communities, or service settings underrepresented?	
What might explain why these populations or communities are less visible?	

WHAT BARRIERS MAY AFFECT VISIBILITY OR ENGAGEMENT?

Consider factors that may affect whether people appear in data systems, engage with services, or trust outreach teams. Check all that may apply:

☐ Language access barriers ☐ Disability or accessibility barriers ☐ Housing instability or frequent movement between locations ☐ Fear of surveillance, enforcement, or consequences ☐ Stigma related to substance use, homelessness, justice involvement, or behavioral health needs ☐ Transportation barriers	☐ Limited access to phones, internet, or reliable communication ☐ Immigration status or documentation concerns ☐ Prior negative experiences with systems or providers ☐ Service hours, locations, or eligibility requirements ☐ Other:

Which barriers appear most important to address?

WHOSE PERSPECTIVES ARE SHAPING INTERPRETATION?

Equity-focused data review should consider not only what data shows, but also who is interpreting it.

Who is involved in reviewing and interpreting outreach or overdose-related data?	
Are peers, outreach staff, community-based organizations, or people with lived and living experience included?	
Do the people interpreting the data have relevant knowledge of the communities being discussed?	
What additional perspectives would strengthen interpretation and planning?	

HOW IS LIVED EXPERIENCE INFORMING OUTREACH DESIGN?

Use this section to identify how lived experience and community knowledge are shaping outreach strategies.

How are peers and outreach teams helping interpret data trends?	

How are community partners helping validate priority populations or outreach locations?	
What risks, barriers, or community dynamics have been identified through qualitative input?	
What outreach strategies have been strengthened because of lived experience or frontline insight?	

ARE OUTREACH STRATEGIES RESPONSIVE TO COMMUNITY NEEDS?

Use this section to consider whether outreach design reflects what is known about community context, trust, access, and engagement.

Outreach Component	Strengths to Build On	Opportunities to Strengthen
Outreach locations		
Outreach timing		
Staffing and peer involvement		
Language access and cultural responsiveness		
Supplies, resources, or services offered		
Messaging and engagement approach		

Referral and linkage pathways		

ACTION PLANNING

Based on the review of equity-focused data, have an overall discussion about priority next steps. Consider questions such as:

- What current practices are helping the team reach communities that have historically faced barriers to care?
- Which populations or communities may need more focused attention based on data, peer input, or community feedback?
- What strengths can be expanded to improve equity in outreach, engagement, or service access?
- What is one change that could make outreach more accessible, trusted, or responsive?
- What should the team revisit during the next data review or outreach planning discussion?

Based on the discussion, identify specific next steps.

Priority Opportunity	**Action Step**	**Lead**	**Timeline / Follow-Up**

TOOL 3.B: PEER + DATA REVIEW WORKSHEET

Designed For: Quick huddles, low connectivity, and real-time decision-making.

How to Use: Use this worksheet to review maps that highlight clusters of incident activity (e.g., heat maps or density maps) or trend lines alongside peer and outreach team input to decide where, when, and how to deploy outreach.

Recommended Users: Outreach staff, peers or people with lived experience, data staff, program supervisors, and relevant community or system partners.

STEP 1: LOOK AT THE DATA

Look at maps, trend lines, or dashboards first. Focus on observation before interpretation.

Review Data: Data source(s) reviewed (check all that apply).

Overdose and Health Data

- ☐ EMS response data
- ☐ Emergency department data
- ☐ Overdose mortality / coroner data
- ☐ Toxicology trends
- ☐ Drug checking data
- ☐ Community naloxone administration reports

High-Risk Transition Data

- ☐ Jail or prison release data
- ☐ Hospital discharge data
- ☐ Shelter or homelessness data

Field and Community Information

- ☐ Outreach team observations
- ☐ Peer recovery specialist input
- ☐ Community partner observations
- ☐ Community feedback or surveys

Other:

Discuss: What patterns, trends, concerns, or changes stand out? (check all that apply)

☐ Geographic cluster or hot spot or new area showing activity
☐ Increase or spike over time
☐ Change in timing (time of day / day of week)
☐ Substance-related signal (fentanyl, xylazine, polysubstance use)
☐ High-risk transition point identified (e.g., jail release, hospital discharge)
☐ Service access or engagement concern
☐ Repeated concern raised by peers, outreach teams, or community partners
☐ Emerging risk not previously observed

Brief observation (1–2 bullets):

STEP 2: REVIEW WHAT OUTREACH TEAMS AND PEERS ARE SEEING

Pause the data. Invite lived experience and field insight.

Ask peers and outreach staff:

- Does this match what you are seeing on the ground?
- What feels different right now?
- What doesn't show up in the data?
- Are there populations or locations that may be underrepresented?

Key peer / field input (brief, non-identifying):

Consider: Does peer input:

☐ Confirm the data
☐ Add context the data misses
☐ Challenge the data interpretation

Brief observation (1–2 bullets):

STEP 3: INTERPRET THE DATA TOGETHER

This is where layering happens. Use data and lived experience together.

Identify: What may be contributing to this pattern?

Service Access and System Factors

☐ Service gap, program closure, or reduction in services
☐ New service, outreach effort, or community resource
☐ Barrier to treatment access or MAT availability
☐ Transportation or access barriers
☐ Change in housing or shelter availability

Community and Population Changes

☐ Movement of people (encampment sweep, seasonal shift, migration between locations)
☐ Recent release or discharge patterns
☐ Emerging population or community not previously identified
☐ Community event, weather event, or seasonal change

Substance Use and Overdose Risks

☐ Change in drug supply or drug potency
☐ Changes in substance use patterns (e.g., polysubstance use, xylazine, stimulant use)
☐ Increased overdose awareness or naloxone distribution

Data and Reporting Factors

☐ Increased visibility due to improved reporting or surveillance
☐ Data quality issue, reporting delay, or incomplete information

Trust and Engagement Factors

☐ Increased enforcement activity or decreased trust in systems

Other:

Discuss: Which factors seem most likely to be influencing the pattern?

Discuss: What are we still unsure about?

What should we adjust based on this combined view?

- ☐ Location
- ☐ Timing
- ☐ Outreach approach or staffing
- ☐ Supplies brought
- ☐ Messaging

STEP 4: PERFORM AN EQUITY CHECK

Before finalizing outreach decisions, consider who may be visible in the data and who may be missing.

Discuss: Who may be less visible in the data?

Identify: What barriers may affect visibility or engagement?

- ☐ Language
- ☐ Disability or accessibility
- ☐ Immigration status or documentation concerns
- ☐ Trust or prior system harm
- ☐ Transportation
- ☐ Housing instability
- ☐ Other:

Discuss: Does this change who, where, or how outreach should occur?

STEP 4: OUTREACH DECISION

Identify: Decision needed today:

- ☐ Deploy outreach
- ☐ Adjust location or timing
- ☐ Change staffing or peer involvement
- ☐ Bring different supplies or messages
- ☐ Continue monitoring
- ☐ Escalate to partner discussion
- ☐ Other:

Decide: What strategies should be used in outreach?

WHERE should outreach focus next?

WHEN is the best time to show up?

WHO should be prioritized?

HOW should teams show up differently?

STEP 5: CLOSE THE LOOP

What should outreach teams report back after deployment?

- ☐ New or shifting hot spots
- ☐ Changes in substances or risk
- ☐ Barriers to engagement

☐ Safety concerns
☐ What worked / didn't work

How will feedback be shared? ☐ Quick huddle ☐ Notes ☐ Text/email

Follow-up owner: _____

When will this be reviewed again? _____

_____

TOOL 3.C: OUTREACH FIELD NOTES WORKSHEET

Designed For: Documenting brief, non-identifying observations from outreach interactions to identify patterns and improve where, when, and how outreach is conducted.

How to Use: Complete the worksheet after outreach or during a team debrief. Record only information that can inform outreach decisions, focusing on patterns, barriers, safety considerations, and approaches that helped or did not help engagement. Review notes in aggregate alongside other data sources. Consider incorporating some or all of this information into electronic documentation.

Recommended Users: Outreach workers, peer outreach staff, outreach leads and supervisors, and staff responsible for reviewing field insights or coordinating outreach strategy.

STEP 1: BASIC CONTEXT (NO IDENTIFIERS)

Date: _____

General location:

- ☐ Encampment area
- ☐ Shelter / transitional housing
- ☐ Street / neighborhood
- ☐ Clinic / hospital area
- ☐ Other (general, not specific address): _____

Time of outreach: ☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight

STEP 2: TYPE OF INTERACTION

(Check all that apply — do not record names, DOBs, or descriptions that could identify someone.)

Who was engaged:

- ☐ Person using drugs
- ☐ Peer / community member
- ☐ Service provider
- ☐ Bystander / family member

Nature of interaction:

- ☐ First-time contact
- ☐ Repeat contact (no identifier)
- ☐ Group interaction

STEP 3: WHAT WAS NOTED (BRIEF SIGNALS)

Emerging risks or patterns observed:

- ☐ Overdose occurred or narrowly avoided
- ☐ Reports of potent supply (e.g., fentanyl, xylazine)
- ☐ Polysubstance use increasing
- ☐ Increased withdrawal or illness
- ☐ New people or movement into area
- ☐ Other, please describe.

Other key observation (1 short sentence):

STEP 4: ENGAGEMENT BARRIERS & SAFETY CONSIDERATIONS

Barriers mentioned or observed:

- ☐ Mistrust or fear of systems
- ☐ Prior negative experiences
- ☐ Language or cultural barrier
- ☐ Transportation or access issue
- ☐ Service hours misaligned

Safety notes for teams (non-specific):

- ☐ Area feels unsafe at certain times
- ☐ Tension with enforcement presence
- ☐ Environmental hazards

STEP 5: WHAT HELPED / WHAT DIDN'T

Outreach approaches that helped engagement:

- ☐ Peer-led interaction
- ☐ Harm-reduction supplies
- ☐ Low-pressure conversation
- ☐ Language-specific outreach

Approaches that did *not* work:

STEP 6: SIGNALS FOR ADJUSTMENT (ACTIONABLE)

Based on this interaction, outreach teams may need to adjust:

- ☐ Location
- ☐ Timing
- ☐ Supplies brought
- ☐ Staffing approach
- ☐ Messaging

Brief note:

STEP 7: SUBMISSION & USE

How will this note be shared? ☐ Paper ☐ Secure form ☐ Debrief/huddle

Reviewed by: ☐ Outreach lead ☐ Peer supervisor ☐ Data liaison

> These notes are reviewed in aggregate with maps and trend data to guide outreach decisions. Individual notes are not shared externally.

TOOL 4.A: AFBSS TEAM SELF-ASSESSMENT TOOL

Designed For: AFBSS program leaders, supervisors, multidisciplinary teams, and quality improvement staff.

How to Use: Complete this assessment individually or as a team to evaluate team-based care practices, identify strengths and gaps, and prioritize opportunities for improvement. Use the results to develop an action plan and track progress over time.

Recommended Users: Program managers, supervisors, behavioral health clinicians, SUD counselors, nurses, peer support specialists, outreach staff, care coordinators, and multidisciplinary AFBSS teams.

The following tool helps teams assess how well AFBSS team-based care is being implemented and identify areas for improvement. It can be completed individually or as a team by rating each statement on a scale from **1 (Not Yet Started); 2 (Emerging); 3 (Established) 4 (Well Integrated); 5 (Fully in place).**

Team Structure and Roles	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
Our team is structured around engagement, treatment, and care coordination functions.	☐	☐	☐	☐	☐
Our team has a “shared understanding of the mission of AFBSS and the goals of team-based care.	☐	☐	☐	☐	☐
Roles are clearly defined, but flexible when needed.	☐	☐	☐	☐	☐
Staff are cross trained to support multiple functions.	☐	☐	☐	☐	☐
Medical, clinical, peer, and care coordination roles are integrated.	☐	☐	☐	☐	☐

Integration of Peer Support Specialists	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
Peer Support Specialists are fully integrated into the team.	☐	☐	☐	☐	☐
Peer Support Specialists participate in team huddles, debriefs and planning.	☐	☐	☐	☐	☐
Peer Support Specialists share responsibility for engagement and follow-up.	☐	☐	☐	☐	☐
Peer Support Specialists receive structured supervision, support and training.	☐	☐	☐	☐	☐
Peer Support Specialists have opportunities for growth and advancement and/or a career ladder.	☐	☐	☐	☐	☐

Caseload and Capacity	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
Caseloads reflect client acuity and complexity.	☐	☐	☐	☐	☐
Caseloads are team-based rather than individually assigned.	☐	☐	☐	☐	☐
Staff have sufficient time for outreach, travel, coordination and documentation.	☐	☐	☐	☐	☐
Caseloads are regularly reviewed and adjusted based on client acuity, engagement needs, and the time required for outreach, and coordination.	☐	☐	☐	☐	☐

Coverage and Continuity	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
We use a defined and documented coverage model (e.g., shared caseload, primary + backup).	☐	☐	☐	☐	☐
Clients are not dependent on a single staff member.	☐	☐	☐	☐	☐
Coverage is maintained during staff absence or transitions.	☐	☐	☐	☐	☐
We have a clear and documented approach for after-hours or urgent needs.	☐	☐	☐	☐	☐

Team Workflows and Communication	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
We hold regular team huddles and debrief to align priorities.	☐	☐	☐	☐	☐
We have regular staff meetings and use recorded notes for others that may not be in attendance.	☐	☐	☐	☐	☐
Communication is timely and is across the team is clear and consistent.	☐	☐	☐	☐	☐
We use structured communication tools (e.g., Situation, Background, Assessment, and Recommendation (SBAR); Huddle, briefs and debrief checklist) when needed.	☐	☐	☐	☐	☐

Team members share a common understanding of client needs and priorities.	☐	☐	☐	☐	☐
All members of team's opinions are respected and listened to during meetings and when discussing patient care and/or operations.	☐	☐	☐	☐	☐

Engagement and Field-Based Care	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
We prioritize outreach and engagement as core functions.	☐	☐	☐	☐	☐
We meet individuals where they are figuratively and literally (centering clients; community, home, etc.).	☐	☐	☐	☐	☐
We persist in engagement even after missed contacts.	☐	☐	☐	☐	☐
Peer Support Specialists and outreach staff are central to engagement efforts.	☐	☐	☐	☐	☐

Supervision and Staff Support	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
Staff receive regular clinical supervision appropriate to scope and experience.	☐	☐	☐	☐	☐
Reflective supervision is available and used.	☐	☐	☐	☐	☐

Supervisors support both clinical and emotional aspects of the work.	☐	☐	☐	☐	☐
Staff feel supported in managing challenging situations.	☐	☐	☐	☐	☐

Training and Skill Development	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
All staff receive ongoing training beyond onboarding.	☐	☐	☐	☐	☐
Training is practical and applied to real cases.	☐	☐	☐	☐	☐
Skills (e.g., Motivational interviewing, harm reduction, trauma informed services) are reinforced in supervision.	☐	☐	☐	☐	☐
Team members learn from each other through case discussion and mentoring.	☐	☐	☐	☐	☐

Rural / Context Adaptation (if applicable)	1 Not Yet Started	2 Emerging	3 Established	4 Well Integrated	5 Fully in place
Staffing model reflects geographic realities.	☐	☐	☐	☐	☐
We use telehealth to extend capacity and reach with our partners and clients.	☐	☐	☐	☐	☐

Outreach is organized to reduce travel inefficiencies.	☐	☐	☐	☐	☐
Staff remain connected despite geographic distance.	☐	☐	☐	☐	☐

ACTION PLANNING BASED ON RESULTS

Use the results to identify priority areas and develop a focused action plan with clear next steps, roles, timelines, and updates.

Focus Area	Action	Owner	Timeline	Status Update

TOOL 4.B: TRAINING, SUPERVISION, AND WORKFORCE RETENTION CHECKLIST

Designed For: Supervisors, program managers, workforce development staff, clinical leaders, and implementation teams responsible for supporting and retaining the AFBSS workforce.

How to Use: Review each section and check items that are currently in place. Use the checklist to identify strengths, gaps, and opportunities to strengthen training, supervision, workforce well-being, and retention.

Recommended Users: Supervisors, training coordinators, workforce development staff, peer leaders, clinical leads, program managers, and implementation teams.

TRAINING AND SKILL DEVELOPMENT

- ☐ Core competencies have been identified for each AFBSS role.
- ☐ A structured onboarding plan is in place for new staff.
- ☐ Training reflects the realities of field-based work and community settings.
- ☐ Workforce and workplace safety training is incorporated into onboarding and ongoing learning.
- ☐ Staff receive regular refresher training and opportunities to strengthen skills over time.
- ☐ Training includes practical application through shadowing, coaching, role-play, or case review.

INTEGRATING TRAINING AND SUPERVISION

- ☐ Training is reinforced through supervision, coaching, and feedback.
- ☐ Case review is used to strengthen skill development and decision-making.
- ☐ Staff receive opportunities to apply new skills in real-world situations.
- ☐ Team meetings support learning, practice, and skill reinforcement.

REFLECTIVE AND CLINICAL SUPERVISION

- ☐ Regular individual supervision is provided.
- ☐ Group or team supervision is provided.
- ☐ Reflective supervision is integrated into routine practice.
- ☐ Staff have opportunities to discuss challenging situations and emotional impacts of the work.
- ☐ Clinical and reflective supervision are balanced to support both quality care and staff well-being.

SUPERVISOR DEVELOPMENT

- ☐ Supervisors receive training on the AFBSS model and workforce expectations.
- ☐ Supervisors have access to ongoing coaching, consultation, or technical assistance.
- ☐ Opportunities exist for supervisor peer learning and support.
- ☐ Supervisors are equipped to support team-based care, peer integration, and field-based decision-making.

TEAM LEARNING AND SUPPORT

- ☐ Team huddles include opportunities for learning and case discussion.
- ☐ Staff regularly share lessons learned and promising practices.
- ☐ Peer workers, clinicians, and other team members learn together whenever possible.
- ☐ Staff have opportunities for collaboration and problem-solving.

BURNOUT PREVENTION AND WORKFORCE WELL-BEING

- ☐ Reflective supervision is used to support resilience and reduce burnout.
- ☐ Caseload expectations reflect the realities of field-based work.
- ☐ Team members have opportunities to debrief difficult situations.
- ☐ Leadership openly acknowledges the emotional demands of the work.
- ☐ Staff well-being is discussed routinely rather than only during times of crisis.
- ☐ Strategies are in place to monitor burnout, compassion fatigue, and workforce stress.
- ☐ Staff are encouraged to use leave, wellness resources, and other supports when needed.

RETENTION AND SUSTAINABILITY

- ☐ Workforce retention is regularly monitored.
- ☐ Career development opportunities are available.
- ☐ Peer workers have opportunities for advancement.
- ☐ Workforce feedback is regularly collected and reviewed.
- ☐ Training and supervision approaches are adjusted based on staff needs and program performance.

Discussion Questions

- Which elements of our training and supervision system are currently strongest?
- Where do staff report needing additional support, coaching, or skill development?

- Which changes would have the greatest impact on staff confidence, well-being, or workforce stability?
-

Top three priorities for the next 12 months:

1.

2.

3.

TOOL 4.C: MOBILE FIELD-BASED SUD SERVICES TRAINING CURRICULUM FOR A MULTIDISCIPLINARY TEAM

Designed For: Organizations developing, implementing, or refining training programs for multidisciplinary mobile field-based SUD teams.

How to Use: Use this resource to identify core training topics, training resources, and implementation approaches that support staff working in community-based, field-based settings. Adapt the curriculum based on team roles, experience levels, and local needs.

Recommended Users: Training coordinators, supervisors, workforce development staff, clinical leaders, peer leaders, program managers, and organizations responsible for onboarding and ongoing staff development.

A **mobile field-based substance use disorder (SUD) services** model requires a **multidisciplinary training curriculum** that equips providers from diverse disciplines. For example: nurses, physicians, social workers, peer support specialists, counselors, pharmacists, and staff—to deliver integrated, evidence-based care in community settings.

CORE TRAINING COMPONENTS

SAMHSA Practitioner Training & Core Curriculum

SAMHSA offers a core curriculum with web-based modules that can be adapted for mobile teams to address on-the-ground compliance and documentation. They cover:

- Organizational readiness and stigma reduction.
- Social determinants of health and trauma-informed care.
- Co-occurring behavioral health and medical conditions.
- Prescribing opioids and medication-assisted treatment (MAT) tools.
- Health information technology and telehealth integration.
- Regulations & recordkeeping for field-based work AHRQ Academy.

AFBSS Mobile Opioid Treatment Programs Webinar

The Models for Mobile Opioid Treatment Programs webinar provides an overview of the evolution of Mobile Opioid Treatment Program (OTP) services, including the history of methadone, key regulatory requirements, and the expansion of care through Mobile OTP units. The webinar also details how mobile services align with Assertive Field-Based

Initiation for SUD treatment services (AFBSS) and how harm-reduction principles continue to shape OTP practice.

- Slide deck with notes
- Slide deck without notes
- Webinar recording

SUD 101 & MOUD-Specific Training

The **SUD Training Portal** is ideal for building foundational knowledge across disciplines. It provides:

- **8-hour SUD 101 Core Curriculum** (free, multiple credit types).
- **Provider Clinical Support Services (PCSS)-MOUD: SUD for the Healthcare Team** (on-demand, 4 modules).
- **Motivational Interviewing** and **individual psychotherapy/counseling** skills.
- **Chronic pain & opioid use disorder** management.
- **Performance in practice** and co-morbidities education.sudtraining.org.

Mobile Crisis Team (MCT) Implementation Toolkit

SAMHSA's **Mobile Crisis Team Services Toolkit** essential for field-based teams operating in unpredictable environments. It includes:

- Crisis intervention strategies.
- De-escalation and safety planning.
- Coordination with law enforcement and EMS.
- Documentation and follow-up protocols.
- Role-specific guidance for each team member irp.cdn-website.com.

Integrated Care & Peer Support Model

The **Community Care Cooperative** (**C3) Substance Use Treatment Integrated Primary Care (IPC) Toolkit** ensures all team members understand their role in a collaborative, patient-centered model. It emphasizes:

- Full integration of MAT and peer support into primary care.
- Recovery coaching and engagement strategies.
- Screening and treatment at all visits.
- Leadership normalization of SUD conversations.

- Provider and staff wellness in high-stress field settings teambasedcaretoolkit.c3aco.org.

CURRICULUM STRUCTURE FOR A MOBILE FIELD TEAM

Phase 1 – Foundational Knowledge

- SAMHSA Core Curriculum modules.
- SUD 101 & MOUD training.
- Trauma-informed and cultural competency.

Phase 2 – Field-Specific Skills

- Mobile Crisis Team crisis intervention & safety protocols.
- Mobile documentation & telehealth use.
- Coordination with community partners.

Phase 3 – Integrated Care & Peer Support Specialist

- MAT administration & monitoring.
- Recovery coaching & engagement strategies.
- Co-occurring disorder management.

Phase 4 – Leadership & Teamwork

- Role clarity for each discipline.
- Crisis communication & interprofessional collaboration.
- Quality improvement in mobile settings.

DELIVERY OPTIONS

- **Web-based courses** (SAMHSA Academy, SUD Training Portal).
- **On-site workshops** using SAMHSA toolkits.
- **Peer-led training** for recovery coaches.
- **Case-based simulations** for outreach and engagement and crisis scenarios.

Tip: Combine SAMHSA's core and MOUD modules with the MCT and IPC toolkits to create a **comprehensive, role-specific, and field-adapted curriculum** that supports both clinical and operational needs of a mobile SUD team.

For more information, review the following:

- SAMHSA Technical Assistance and Training Directory

- Providers Clinical Support System - SUD Training Catalog
- SAMHSA Mobile Crisis Team Services - An Implementation Toolkit
- Community Care Cooperative Team-Based Care Toolkit for Integrated Primary Care

TOOL 4.D: WORKFORCE WELLNESS AND BURNOUT PREVENTION CHECK-IN

Designed For: Routine team check-ins, supervision discussions, workforce wellness planning, and retention-focused conversations.

How to Use: Use this worksheet to identify workforce stressors, protective factors, and practical supports that can help reduce burnout, compassion fatigue, and moral distress. This tool can be used during supervision, team meetings, or periodic workforce wellness reviews.

Recommended Users: Supervisors, program managers, clinical leads, peer leaders, workforce development staff, and AFBSS team members.

CURRENT WORKFORCE STRESSORS

Use this section to identify factors that may be contributing to stress, burnout, or moral distress.

- ☐ High caseloads or workload intensity
- ☐ Frequent crisis response or high-acuity situations
- ☐ Insufficient supervision or coaching
- ☐ Role confusion or unclear expectations
- ☐ Limited staffing or coverage gaps
- ☐ Exposure to trauma, overdose, instability, or loss
- ☐ Difficulty accessing needed services for clients
- ☐ Team communication challenges
- ☐ Limited opportunities to debrief difficult situations

PROTECTIVE FACTORS AND SUPPORTS

Use this section to identify what is already helping staff remain supported, connected, and effective. Then, brainstorm strategies to strengthen protective factors.

Protective Factors

- ☐ Reflective supervision
- ☐ Clinical supervision
- ☐ Team huddles or case consultation
- ☐ Peer support among staff
- ☐ Reasonable caseload expectations
- ☐ Clear roles and responsibilities

- ☐ Opportunities to ask for help early
- ☐ Debriefing after difficult events
- ☐ Career development or advancement opportunities

Strategies to strengthen protective factors:

ARMS-INFORMED REFLECTION

The ARMS framework is one way to approach workforce wellness discussions. Discuss the following components: Assess, Recover, Mitigate, and Strengthen.

Assess	What stressors, burnout risks, or moral distress factors are most affecting the team right now?
Recover	What does the team need to reduce stress load or recover after difficult work?
Mitigate	What can supervisors or leaders adjust to reduce preventable stressors?
Strengthen	What protective factors should be expanded or reinforced?

Team Discussion Questions

- What workforce strengths are helping staff stay engaged and effective?
- Which stressors are most affecting staff well-being or retention?
- Where are there opportunities to strengthen supervision, debriefing, or team support?
- What changes could reduce burnout risk while improving continuity of care?
- What support do supervisors need to better support their teams?
- What is one practical change the team could make in the next 30 days?

TOOL 5.A: PARTNERSHIP ASSESSMENT TOOL

Designed For: Organizations evaluating the strength and effectiveness of existing partnerships.

How to Use: Assess partnership characteristics such as trust, communication, accountability, and complementary strengths. Use results to identify opportunities for improvement.

Recommended Users: County staff, healthcare providers, community-based organizations, and collaborative leadership teams.

Partner Organization:

Role(s) Provided:

Historical Relationship:

Partnership Characteristic	Rating	Notes
Mutual trust	1 2 3 4 5	
Shared accountability	1 2 3 4 5	
Communication	1 2 3 4 5	
Role clarity	1 2 3 4 5	
Complementary strengths	1 2 3 4 5	
Follow-through on commitments	1 2 3 4 5	

Discussion Questions

- What is working well in this partnership?
- Where are coordination challenges occurring?
- What changes could strengthen trust, communication, or accountability?

TOOL 5.B: PARTNERSHIP NETWORK MAPPING WORKSHEET

Designed For: County behavioral health leaders, implementation teams, and staff responsible for developing and managing partnerships.

How to Use: Identify existing and potential partners, document their role in supporting AFBSS, and identify opportunities to strengthen collaboration, coordination, and continuity of care.

Recommended Users: Behavioral health leadership, program managers, outreach teams, community engagement staff, and partnership workgroups.

PART 1: MAP YOUR CURRENT PARTNER NETWORK

HOUSING & BASIC NEEDS PROVIDERS

Homeless services agencies, Continuum of Care (CoC) programs, shelters, housing providers, food banks, hygiene programs, and other organizations addressing basic needs.

Current Partner(s) & Role in Supporting Clients

Gaps

CLINICAL & HEALTH CARE PARTNERS

Managed care plans, FQHCs, primary care providers, hospitals, emergency departments, street medicine teams, pharmacies, harm reduction programs, and other healthcare providers.

Current Partner(s) & Role in Supporting Clients

Gaps

PUBLIC SAFETY & CRISIS PARTNERS

Crisis teams, law enforcement, EMS, mobile crisis services, and other partners that may identify, engage, or respond to individuals in crisis.

Current Partner(s) & Role in Supporting Clients

Gaps

COMMUNITY & PEER SUPPORT PARTNERS

Peer support specialists, recovery community organizations, community-based organizations, recovery residences, faith-based organizations, and culturally specific community partners.

Current Partner(s) & Role in Supporting Clients

Gaps

SPECIALIZED SERVICES & SOCIAL SUPPORTS

Employment services, education and workforce development programs, family support services, benefits programs, legal aid, transportation services, and other organizations supporting long-term stability and recovery.

Current Partner(s) & Role in Supporting Clients

Gaps

PART 2: NETWORK GAPS AND OPPORTUNITIES

1. **Current Strengths:** Which partnerships are most effective in supporting engagement, treatment, recovery, and care coordination?

2. **Current Gaps:** Which services, populations, or community needs are not adequately supported through existing partnerships?

3. **Coordination Challenges:** Where do breakdowns most often occur?

   ☐ Referrals

   ☐ Information sharing

   ☐ Care transitions

   ☐ Communication

   ☐ Role clarity

   ☐ Follow-up

   ☐ Other:

4. **Reflection Questions**

- Which partnerships are most critical to achieving AFBSS goals?
- Which populations may have unmet needs because of gaps in the current network?
- Where are handoffs, referrals, or transitions most likely to break down?
- Which relationships should be strengthened or formalized?
- Are community-based organizations, peers, and people with lived experience adequately represented in the network?
- What one partnership would have the greatest impact if strengthened over the next year?

TOOL 5.C: REGIONAL PARTNERSHIP READINESS ASSESSMENT

Designed For: County leaders, behavioral health planners, and implementation teams exploring cross-county or regional solutions to workforce, access, infrastructure, or service delivery challenges.

How to Use: Complete the assessment individually or as a group to evaluate whether a shared regional approach could help address a specific challenge. Use responses to identify opportunities, potential partners, and next steps for exploration.

Recommended Users: Recommended users include county behavioral health and SUD leaders, AFBSS planning teams, rural and frontier counties, regional collaboratives and partner organizations, and workforce planning staff.

HOW TO USE THIS ASSESSMENT

This assessment is designed to support planning and discussion rather than generate a formal score. As you complete the questions, focus on identifying whether:

1. A clearly defined problem exists that may be difficult for your county to solve independently.
2. The problem extends beyond county boundaries or affects neighboring counties in similar ways.
3. Resources, infrastructure, or expertise could realistically be shared across counties or partner organizations.
4. Potential partners and leadership support exist to explore a collaborative approach.

When reviewing your responses, look for patterns rather than totals. A regional approach may be worth exploring when:

- Multiple challenges relate to access, workforce, geography, transportation, infrastructure, or sustainability.
- Neighboring counties face similar barriers.
- Shared resources could reasonably improve efficiency or access.
- Potential partners appear willing to collaborate.

A regional approach may be less appropriate when:

- The challenge is unique to a single county.
- Existing local resources can reasonably address the problem.
- There is limited opportunity to share resources or infrastructure.

- Significant legal, operational, financial, or partnership barriers exist with no clear pathway to resolution.

The goal of this assessment is not to determine whether regional collaboration is required, but rather to help counties decide whether further exploration of a regional strategy may be beneficial.

STEP 1. DEFINE THE PROBLEM

Before considering a regional approach, clearly identify the challenge you are trying to solve.

What implementation challenge are you experiencing? *Select all that apply*.

☐ Limited access to medications for addiction treatment (MAT)

☐ Limited prescriber capacity

☐ Workforce recruitment and retention challenges

☐ Transportation barriers

☐ Long travel distances to treatment services

☐ Limited mobile treatment capacity

☐ Limited access to specialty expertise

☐ Low service volume that makes a local program difficult to sustain

☐ After-hours or specialized coverage gaps

☐ Limited referral or care coordination capacity

☐ Other: _____

Why is this challenge difficult to solve locally?

STEP 2. ASSESS WHETHER THE CHALLENGE EXTENDS BEYOND COUNTY BOUNDARIES

For each statement below, indicate whether it applies to your county.

Assessment Question	Yes	No	Unsure
Individuals regularly access or receive services outside the county.	☐	☐	☐
Residents near county borders may be closer to services in neighboring counties.	☐	☐	☐
Neighboring counties experience similar workforce, access, or infrastructure challenges.	☐	☐	☐
Transportation barriers affect access across a broader geographic region.	☐	☐	☐
Existing county-specific solutions may duplicate resources that could potentially be shared.	☐	☐	☐
A regional approach could improve access for more than one county.	☐	☐	☐

Key Observations

STEP 3. IDENTIFY POTENTIAL SHARED RESOURCES

Regional partnerships are most successful when they address a clearly defined problem through shared resources or infrastructure.

Which resources could potentially be shared? *Select all that apply.*

☐ Prescriber capacity

☐ Nursing or clinical staff

☐ Peer support specialists

☐ Community health workers or navigators

☐ Telehealth infrastructure

☐ Access-line or hotline operations

☐ Mobile treatment services

☐ Medication-unit infrastructure

☐ Pharmacy partnerships

☐ Transportation resources

☐ Referral and care-coordination systems

☐ Training or clinical consultation

☐ Data, reporting, or evaluation support

☐ Administrative or contracting functions

☐ Other: _____

Which shared resource could have the greatest impact on the identified challenge?

STEP 4. ASSESS PARTNERSHIP FEASIBILITY

Regional models require commitment, leadership, and coordination across organizations.

Readiness Question	Yes	No	Unsure
County leadership would support exploring a regional partnership.	☐	☐	☐
Potential partner counties have a similar need or challenge.	☐	☐	☐
Existing relationships may support regional collaboration.	☐	☐	☐
At least one county or organization could serve as a lead coordinator.	☐	☐	☐
Key stakeholders (clinical, fiscal, legal, contracting, compliance, data, IT) could participate in planning.	☐	☐	☐
Partners would be willing to test a limited pilot or demonstration project.	☐	☐	☐

Potential Partners

Identify counties, organizations, or service providers that may have an interest in collaborating.

Potential Partner	Shared Need or Opportunity

STEP 5. REFLECT ON FEASIBILITY AND VALUE

What benefits might a regional approach provide? *Select all that apply.*

☐ Improved treatment access

☐ Increased prescriber capacity

☐ Improved workforce sustainability

☐ Reduced travel burden

☐ Better care coordination

☐ Expanded geographic coverage

☐ Reduced duplication of services

☐ Shared infrastructure costs

☐ Increased sustainability

☐ Improved continuity of care

☐ Other: _____

What potential challenges would need to be addressed? *Select all that apply*.

☐ Governance and decision-making

☐ Funding and sustainability

☐ Staffing and supervision

☐ Data sharing

☐ Documentation requirements

☐ Privacy and consent

☐ Transportation logistics

☐ Cross-county responsibilities

☐ Regulatory requirements

☐ Other: _____

ASSESSMENT REFLECTION

After completing this assessment, consider the following questions.

What challenge are we trying to solve?

Is this challenge primarily local, regional, or both?

☐ Primarily local

☐ Primarily regional

☐ Combination of local and regional factors

What resources, capabilities, or infrastructure could potentially be shared?

Which counties, providers, or organizations may be appropriate partners?

Based on this assessment, what is our preliminary conclusion?

☐ County-based solutions appear sufficient at this time.

☐ A limited regional partnership may warrant further exploration.

☐ Regional collaboration appears to be a strong option for addressing the identified challenge.

☐ Additional information is needed before a determination can be made.

Key considerations moving forward

TOOL 5.D: MULTI-COUNTY PARTNERSHIP LIFECYCLE PLANNING WORKSHEET

Designed For: Organizations building new partnerships or formalizing existing relationships.

How to Use: Work through each stage of partnership development to clarify purpose, expectations, roles, and next steps.

Recommended Users: Program leaders, implementation teams, contract managers, community engagement staff, and partner organizations.

Potential Partner:	
Purpose of Partnership:	

STEP 1: INITIATE – WHO SHOULD WE PARTNER WITH AND WHY?

- Can this organization do something that we cannot do alone?
- What shared challenge or opportunity could this partnership address?
- Why is this partner important to AFBSS implementation?
- Which populations would benefit from this partnership?
- Are there communities experiencing disparities that this partnership could help address?
- Does this partner have trusted relationships with populations that are difficult to engage?
- Whose perspectives are currently missing from partnership discussions?

Notes:

STEP 2: NEGOTIATE – HOW WILL WE WORK TOGETHER?

- What does each organization hope to gain from the partnership?
- What is each organization willing and able to contribute?
- Which responsibilities will be shared?
- Which responsibilities will remain separate?
- How will referrals, communication, and follow-up occur?
- How will accountability be maintained?
- How will services remain accessible, culturally responsive, and relevant?
- How will people with lived experience be incorporated into planning and decision-making?

Notes:
Key Contributions of Partner:
Key Contributions of Our Organization

STEP 3: FORMALIZE – HOW WILL WE OPERATIONALIZE THE PARTNERSHIP?

- What type of agreement is most appropriate?
- Are roles and responsibilities documented?
- Have communication pathways been defined?
- Have escalation pathways been defined?
- How will information sharing and confidentiality be managed?
- How will partnership performance be monitored?
- Are equity, language access, and community engagement expectations documented?
- How will partners identify and address disparities?

Notes:
Description of Agreement & Terms:

STEP 4: IMPLEMENT & MONITOR – HOW WILL IT WORK ON THE GROUND? HOW WILL WE MONITOR?

- Are the agreed-upon processes working as intended?
- Are referrals and handoffs occurring smoothly?
- What barriers or frustrations are emerging?
- Does the partnership continue to provide value to both organizations?
- Are priority populations successfully accessing services?
- Are some communities experiencing different outcomes or barriers?
- How is community feedback informing improvements?
- What adjustments are needed to improve equity, access, or coordination?

Notes:

PARTNERSHIP ACTION PLAN

Document the next steps needed to establish or formalize this partnership.

Next Step	**Point Person**	**Timeline**

TOOL 6.A: HARM REDUCTION PRACTICE REVIEW

Designed For: AFBSS programs, behavioral health providers, community-based organizations, supervisors, quality improvement teams, and multidisciplinary care teams.

How to Use: Review each practice area and assess the extent to which it is reflected in current policies, workflows, team practices, and service delivery. Identify areas of strength, barriers to implementation, and opportunities for improvement. Complete individually or as part of a team discussion, quality improvement initiative, or program planning process.

Recommended Users: Program leaders, supervisors, outreach staff, peer support specialists, SUD counselors, behavioral health clinicians, nurses, prescribers, care coordinators, and quality improvement teams.

Practice Area	Rating (1-5)	Current Practice	Action Needed
Services do not require readiness for abstinence.			
Ongoing substance use does not automatically result in discharge.			
Missed appointments trigger outreach and re-engagement efforts.			
Naloxone education and distribution are routinely offered.			
Safer-use education and harm reduction supplies are available when appropriate.			
Client goals and priorities inform treatment planning.			

Practice Area	Rating (1-5)	Current Practice	Action Needed
Success is measured beyond abstinence alone.			
Staff consistently use person-centered, non-stigmatizing language.			
Individuals are actively involved in care planning and decision-making.			
Medications for addiction treatment are available with minimal barriers or delays.			
Services remain flexible and responsive to changing needs and readiness for change.			
Teams routinely address housing, medical, behavioral health, and social needs alongside substance use concerns.			

Rating	Description
1	Not implemented
2	Implemented inconsistently
3	Partially implemented
4	Mostly implemented
5	Fully integrated into routine practice

Reflection Questions

- Where are harm reduction principles most strongly reflected in current practice?
- Which policies, procedures, or requirements may unintentionally create barriers to engagement?
- How does the program define success beyond abstinence?
- What changes would have the greatest impact on engagement, safety, and access to care?
- What is one improvement the team could begin implementing within the next 30 days?

TOOL 6:B: LOW-BARRIER SERVICE DELIVERY SELF-ASSESSMENT

Designed For: AFBSS programs, supervisors, quality improvement teams, behavioral health providers, community-based organizations, and multidisciplinary care teams.

How to Use: Review each access area and assess whether current policies, workflows, and service delivery approaches create unnecessary barriers to engagement or treatment. Identify barriers, prioritize opportunities for improvement, and develop concrete action steps to increase access and reduce service friction. Consider each area, consider the barriers, and write down one or two approaches that would reduce barriers in that area.

Recommended Users: Program leaders, supervisors, outreach staff, peer specialists, SUD counselors, behavioral health clinicians, nurses, prescribers, care coordinators, administrative staff, and quality improvement teams.

Access Area	One or Two Ways to Reduce Barriers
Intake and enrollment	
Same-day assessment	
Medication access	
Counseling requirements	
Scheduling and walk-ins	
Field-based service options	
Telehealth access	

Access Area	One or Two Ways to Reduce Barriers
Response to missed appointments	
Language and communication access	
Documentation and paperwork requirements	
Eligibility and enrollment requirements	
Re-engagement after disengagement	
Support for individuals with housing instability	
Accommodation of client preferences and goals	
Access to harm reduction services and supplies	

Reflection Questions

- Which barriers are most likely to prevent individuals from initiating services?
- Which barriers are most likely to prevent individuals from remaining engaged?
- What processes were designed for administrative convenience rather than client access?
- Which barrier could be addressed within the next 30 days?
- What would make it easier for individuals to access services when they are ready?
- What is one requirement that could be removed, shortened, combined, or completed after care begins?

TOOL 6.C: CONSENT TO TREATMENT IN THE FIELD – TOOLS

Designed For: Field-based SUD treatment providers obtaining informed consent.

How to Use: Use during patient encounters to guide informed consent discussions, assess capacity when needed, and document consent or declination.

Recommended Users: Prescribers, nurses, behavioral health clinicians, outreach staff, street medicine teams, and mobile health providers.

CHECKLIST IN THE FIELD

1. **Communication**
   - ☐ Use interpreter (if needed)
   - ☐ Patient understands language
   - ☐ Consider health literacy
   - ☐ Teach-back or confirm understanding
   - ☐ Trauma-informed Communication Approach
     - **Transparency**: Explain every action and next steps clearly before proceeding.
     - **Nonjudgmental**: Meet basic needs first; do not demand immediate behavioral change.
     - **Choice and Control**: Allow the patient to direct the pace and scope of care; recognize their absolute right to decline treatment.
     - **Consistent, Ongoing Communication**: Build trust and relationship.

2. **Obtain Informed Consent for Treatment**
   - ☐ Explain reason for evaluation
   - ☐ Explain planned services
   - ☐ Name of medication(s)
   - ☐ Discuss expected benefits
   - ☐ Discuss foreseeable risks
   - ☐ Discuss common side effects
   - ☐ Discuss reasonable treatment alternatives
   - ☐ Inform patient of right to decline or stop treatment at any time
   - ☐ Answer patient's questions and respond to patient's concerns
   - ☐ Document consent (including signature) or declination of services

3. **Assess Decision-Making Capacity (If capacity is in question)**
   - ☐ Patient is alert and able to communicate a choice
   - ☐ Patient understands their medical/behavioral health condition
   - ☐ Patient understands the proposed treatment
   - ☐ Patient appreciates the risks and benefits of accepting or declining treatment
   - ☐ Patient reasons through available options

4. **Documentation**
   - ☐ Informed consent to treatment, including signature
   - ☐ When written or electronic signatures are unavailable, document verbal consent in Electronic Health Record (EHR).
   - ☐ Declination of treatment (if applicable)
   - ☐ Capacity (if applicable)
   - ☐ Interpreter (if applicable)
   - ☐ Follow-up plan/recommendations

SOURCES

California's general informed consent doctrine for medical treatment is grounded in *Cobbs v. Grant*, 8 Cal. 3d 229 (1972), and subsequent California case law, which require providers to disclose information material to a patient's decision to accept or decline treatment, including material risks, benefits, and reasonable alternatives. California statutes and regulations impose consent-related requirements in behavioral health and other specific contexts, but California does not provide a standalone statutory definition of informed consent specifically for SUD treatment.

AFBSS CONSENT DOCUMENTATION AND CHARTING GUIDANCE

Consider using the following information when documenting consent and charting into an electronic health record when initiating treatment for opioid use disorder, alcohol use disorder, or other substance use disorders in street medicine/field-based settings.

Treatment Discussion

The following information was reviewed with the patient using plain, understandable language:

Nature of the Condition

Discussed the diagnosis of substance use disorder as a chronic, treatable medical condition and reviewed available treatment options.

Proposed Treatment

Discussed the recommended treatment plan, which may include:

- Harm reduction strategies
- Behavioral health counseling and recovery supports
- Referral to specialty treatment when appropriate
- Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD), including:
  - Buprenorphine
  - Methadone (through an Opioid Treatment Program)
  - Naltrexone
- Medications for Alcohol Use Disorder, when appropriate (e.g., naltrexone,)

Expected Benefits

Discussed that treatment may:

- Reduce opioid or alcohol cravings
- Reduce withdrawal symptoms
- Decrease overdose risk
- Improve physical and mental health
- Reduce risk of infectious disease and other complications

Medical Risks

Discussed potential medication risks, including as applicable:

- Medication interactions
- Side effects
- Risk of overdose if opioids are resumed after periods of abstinence
- Need for ongoing monitoring and follow-up

Risks of Declining Treatment

Discussed that declining treatment may increase the risk of:

- Continued substance use
- Overdose
- Infectious complications
- Hospitalization
- Loss of functioning
- Death

Alternatives

Reviewed alternatives, including:

- Behavioral treatment without medication
- Referral to specialty substance use treatment
- Recovery support services
- Choosing no treatment at this time

Naloxone Education

Discussed overdose prevention strategies and offered naloxone education and distribution, when available.

Voluntary Participation

Confirmed that:

- Participation in treatment is voluntary.
- The patient may refuse or discontinue treatment at any time.
- The patient may request changes to the treatment plan.
- Consent may be withdrawn without loss of access to other available medical services.

Patient Understanding

The patient was encouraged to ask questions. The patient expressed an understanding of the treatment plan.

Consent

Patient consented to or declined treatment. Details provided:

Date/Time: _____

Provider Name: _____

Signature: _____

TOOL 6.D: MULTIDISCIPLINARY TEAM MEETING CASE PRESENTATION TEMPLATE (SAMPLE)

Designed For: AFBSS teams conducting case conferences, care planning meetings, huddles, acuity reviews, and multidisciplinary case consultations.

How to Use: Use this guide to structure discussions about individuals with complex medical, behavioral health, substance use, housing, or social service needs. The goal is to ensure the team develops a shared understanding of the individual's needs, priorities, risks, strengths, and next steps. Focus discussion on care coordination, problem-solving, and clear assignment of responsibilities.

Recommended Users: Outreach staff, peer support specialists, SUD counselors, nurses, prescribers, care coordinators, behavioral health clinicians, supervisors, housing navigators, and multidisciplinary care teams.

Date:		Staff Presenting:	
Client Name:		Age:	
SITUATION & BACKGROUND			
Situation			
Background Include cultural, religious and health equity/literacy factors that inform the client and family approach to health			
CARE PROVIDERS			
Healthcare Providers:			
AFBSS Team Providers:			
Primary Care:			
MAT Providers:			
Specialty:			

Housing:	
CBOs:	
Others:	
INVOLVEMENT IN OTHER HEALTH-RELATED PROGRAMS	
Targeted Case Management:	
Enhanced Care Management:	
Home and Community Based Alternatives:	
Public Health:	
Home Visiting:	
Other:	
FAMILY OR SOCIAL SUPPORTS:	
REFERRALS	
Community Supports or Other Referrals	
Referral Status and Adherence	
ASSESSMENT AND CONCERNS	

REASON FOR CASE PRESENTATION OR THE PROBLEM		
☐ Condition not improving	☐ Exacerbation of condition	☐ New client
☐ Recent ER/hospitalization	☐ Medication management	☐ Treatment challenges
☐ Return to use	☐ Recovery support planning (including graduation)	☐ Transition of level of care
☐ Routine MDCT/Care Goals review	☐ Other	

Recent Results: include date of result		
Laboratory:	PHQ9:	GAD7:
Radiology:	CAGEAID:	Other:

BIOPSYCHOSOCIAL ASSESSMENT AND CONCERNS
Diagnoses (include medical, physical, behavioral, substance use)
Medications (list) and include medication adherence
Recent ER Visits/Hospitalizations/Use of Crisis Services: Include date and location
Health Concerns (physical, mental health, substance use, social determinants of health)

HOUSING STATUS	
Current Support System:	At risk of being Unhoused? ☐Yes ☐No Currently being Unhoused? ☐Yes ☐No Unhoused prior to this treatment? ☐Yes ☐No
CLIENT'S GOALS, STRENGTHS AND BARRIERS	
STAGE OF CHANGE REGARDING PRIMARY HEALTH/MH/SUD CONCERNS	
Pre-contemplative Contemplative Action	
What do you need from this meeting? Recommendation and Action List: Include Timeframe and ECM Team Member Responsible	
Care plan development/revision: Specialty medical or mental health referral: Medication initiation/change: Behavioral health intervention modification (for SUD or behavioral health): Level of care transition: Contact with client family or support: Recovery management planning: Change in client engagement plan:	Maintenance Return to use Comments:
Recommendation/Plan	
Additional Items	

TOOL 6.E: AFBSS QUALITY IMPROVEMENT MEASURE PLANNER

Designed For: Program leaders, supervisors, quality improvement teams, administrators, and multidisciplinary AFBSS teams.

How to Use: Use this worksheet to select 1 or 2 priority areas for quality improvement, identify meaningful measures, and develop an action plan for reviewing and responding to performance data.

Recommended Users: Program managers, supervisors, quality improvement staff, county administrators, care coordinators, data analysts, and multidisciplinary AFBSS teams.

STEP 1: REFLECT ON QUALITY IMPROVEMENT PRIORITES

Discuss as a group:

- Which measures provide the clearest picture of whether individuals are successfully engaging in care?
- Are there important outcomes we value but are not currently measuring?
- What data already exist that could be used for improvement efforts?
- Which improvement opportunity would have the greatest impact on client outcomes, engagement, or access?

STEP 2: IDENTIFY PRIORITY AREAS

Identify the priority area(s) your team would like to focus. For each priority area, complete the worksheet below.

☐ Harm Reduction	☐ Access & Timeliness
☐ Engagement & Retention	☐ Integrated & Whole-Person Care
☐ Functional Outcomes	☐ Experience & Trust
☐ Equity	☐ Implementation Capacity
☐ Other: _____	

STEP 3: QUALITY MEASURE ACTION PLAN

Priority Area: _____

DEFINE SUCCESS Discuss and define the success that you're wanting to achieve.
What are we trying to improve?
Why is this important to our program and the people we serve?

IDENTIFY POSSIBLE MEASURES

Discuss possible measures that could track performance in this priority area and then select the measures you want to use.

Possible Measures	Baseline (if known)	Desired Target	Data Source

CREATE AN IMPROVEMENT PLAN

Discuss changes you can test, and then select those changes.

What change(s) could we test?	Who is responsible for leading this effort?	How often will progress be reviewed?

EVALUATE RESULTS

Set a day and time in which the team will evaluate the results.

What happened?
What did the team learn?
What should we continue, change, or adapt next?

TOOL 6.F: TEAM-BASED CARE AND TEAMSTEPPS IMPLEMENTATION PLANNING WORKSHEET

Designed For: AFBSS supervisors, multidisciplinary teams, program managers, quality improvement teams, and county behavioral health leaders.

How to Use: Review the overview and key TeamSTEPPS concepts below. Complete the worksheet as a team to assess current communication and coordination practices, identify opportunities for improvement, and select strategies that can strengthen team performance, service coordination, and client outcomes.

Recommended Users: Program managers, supervisors, physicians, nurses, behavioral health clinicians, peer support specialists, outreach staff, care coordinators, quality improvement teams, and multidisciplinary AFBSS teams.

OVERVIEW OF TEAMSTEPPSS

TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based framework designed to improve team performance, communication, and patient safety. Core concepts include:

- Structured communication
- Leadership and shared accountability
- Situation monitoring and situational awareness
- Mutual support and collaboration

These concepts align closely with AFBSS principles related to multidisciplinary care, coordinated service delivery, and integrated treatment planning.

The TeamSTEPPS® 3.0 curriculum, developed by the Agency for Healthcare Research and Quality (AHRQ), provides a framework for building high-performing teams through four core competencies: communication, leadership, situation monitoring, and mutual support.

Integrating principles of this team-based model into AFBSS strengthens the multidisciplinary coordination required to support individuals with complex medical, behavioral health, and social needs. The framework provides a shared language and structured approaches that enable physicians, nurses, behavioral health clinicians, peer support specialists, care coordinators, and outreach staff to function as a cohesive team while managing high-acuity cases across community settings.

TEAMSTEPPS COMMUNICATION TOOLS FOR TEAM-BASED CARE

AFBSS teams often work across settings, providers, and systems of care while serving individuals with complex needs and elevated risks. Structured communication tools can help improve coordination, support safe transitions, strengthen teamwork, and reduce the risk of missed information during outreach, care coordination, crisis response, and treatment planning. The TeamSTEPPS tools below provide practical strategies for improving communication, situational awareness, decision-making, and accountability.

Reflection Questions

- Where does communication most frequently break down?
- How does the team maintain continuity during staff absences or transitions?
- Are responsibilities clearly assigned following meetings and case conferences?
- What communication practice would most improve care coordination?
- How can the team strengthen shared accountability while maintaining clear ownership of tasks?

Tool	What It Helps With	Use When…
SBAR (Situation, Background, Assessment, Recommendation)	Organizing and communicating critical information.	Escalating concerns, provider communication, and multidisciplinary care coordination.
Closed-Loop Communication	Confirming information is received, understood, and acknowledged.	Assigning tasks, coordinating care, responding to crises, and discussing safety concerns.
Daily Huddle Component Kit	Conducting structured team huddles to coordinate services and support daily team communication.	Coordinating care on a daily basis.
Handoffs	Transferring information, responsibility, and accountability.	Transitions between providers, programs, hospitals, housing, or levels of care.
I-PASS (Illness Severity, Patient Summary, Action	Standardizing handoffs and transitions in care.	Hospital discharges, staff transitions, and

Tool	What It Helps With	Use When…
List, Situation Awareness & Contingency Planning, Synthesis by Receiver)		multidisciplinary case coordination.
STEP (Status of Individual, Team Members, Environment, Progress Toward Goals)	Maintaining situational awareness.	Huddles, outreach planning, case reviews, and high-acuity situations.
I'M SAFE (Illness, Medication, Stress, Alcohol/drugs, Fatigue, Eating and elimination)	Assessing staff readiness and safety.	Outreach activities, crisis response, field-based work, and other high-stress situations.
STAR (Stop, Think, Act, Review)	Improving decision-making and reducing errors.	Crisis response, outreach planning, medication-related activities, and quality improvement efforts.
CUS (Concerned, Uncomfortable, Safety Issue)	Raising and escalating safety concerns.	Client safety concerns, overdose risk, unsafe environments, care transitions, or team decisions.
DESC (Describe, Express, Suggest, Consequences)	Addressing conflict and difficult conversations.	Care planning disagreements, communication challenges, workflow issues, or safety concerns.

TEAMSTEPPS WORKSHEET

The following worksheet is designed to help teams assess current team functioning, identify communication and coordination challenges, and develop a plan for improvement. Begin by rating your team's current practices across key areas of team-based care. Use the results to identify one or two priority areas for improvement, select evidence-based communication or coordination strategies, and develop a small-scale improvement plan. After implementing the change, revisit the worksheet to evaluate results, capture lessons learned, and identify next steps. Teams may complete this worksheet during quality improvement meetings, program planning sessions, team retreats, or supervision activities to strengthen collaboration, care coordination, and service delivery over time.

Step 1: Assess Current Team-Based Care Practices

Rate your team's current performance.

Practice Area	Rating (1-5)	Notes
Team members share information effectively.		
Roles and responsibilities are clear.		
Care plans are coordinated across disciplines.		
Team members share accountability for outcomes.		
Communication occurs consistently between team members.		
Care transitions are well coordinated.		
Team members feel comfortable raising concerns.		
Outreach, treatment, and care coordination activities are well integrated.		
The team responds effectively to changing client needs and acuity.		
Team meetings result in clear next steps and ownership.		

Rating	Description
1	Needs Significant Improvement
2	Inconsistently Implemented
3	Partially Implemented
4	Mostly Implemented
5	Consistently Implemented

STEP 2: IDENTIFY PRIORITY AREAS FOR IMPROVEMENT

Based on your ratings, which areas should your team focus on first?

☐ Communication	☐ Shared Accountability
☐ Care Coordination	☐ Team Roles and Responsibilities
☐ Care Transitions	☐ Managing High-Acuity Clients
☐ Meeting Structure and Follow-Up	☐ Workflow Coordination
☐ Other: _____	

Why is this area a priority?

STEP 3: SELECT TEAMSTEPPS STRATEGIES

Which tools or practices could help address the challenge?

Challenge	TeamSTEPPS Tool / Strategy	How Will It Be Used?

Examples include:

- SBAR (Situation, Background, Assessment, Recommendation)
- Closed-Loop Communication
- Daily Huddle Component Kit
- Handoffs
- I-PASS (Illness Severity, Patient Summary, Action List, Situation Awareness & Contingency Planning, Synthesis by Receiver)
- STEP (Status of Individual, Team Members, Environment, Progress Toward Goals)
- I'M SAFE (Illness, Medication, Stress, Alcohol/drugs, Fatigue, Eating and elimination)
- STAR (Stop, Think, Act, Review)
- CUS (Concerned, Uncomfortable, Safety Issue)
- DESC (Describe, Express, Suggest, Consequences)

STEP 4: CREATE AN IMPROVEMENT PLAN

What specific change will the team test?
Who will lead this effort?

When will implementation begin?
How will success be measured?

STEP 5: EVALUATE AND ADAPT

What happened?
What did the team learn?
What should be continued, modified, or expanded?

TOOL 7.A: MEDICATIONS FOR ALCOHOL USE DISORDER QUICK REFERENCE GUIDE

This resource is intended as a quick-reference guide and should not replace clinical judgment, supervision, or consultation with a qualified prescriber. Medication selection and dosing must be individualized based on patient-specific factors, current clinical guidelines, and organizational policies. Always verify dosing recommendations and treatment protocols using current approved sources before implementation.

Designed For: Quick reference to medication options for alcohol use disorder (AUD).

How to Use: Compare medication options, dosing, monitoring, and precautions to support individualized treatment planning. Verify current prescribing guidance before use.

Recommended Users: Prescribers, nurses, pharmacists, and other clinical staff supporting AUD treatment.

Naltrexone| FDA-Approved for AUD

First-line medication for AUD. Reduces cravings and heavy drinking. Consider using when goal is to reduce heavy drinking or stop drinking; can be started while the patient is still drinking. Monthly injection may help when adherence is a concern, or client is returning to a trigger environment.

HOW TO START

Confirm patient is not taking opioids; consider toxicology to verify.

Oral: often 25 mg daily for 1–3 days, then 50 mg daily if tolerated.

Injection can begin once opioid use is excluded.

TYPICAL DOSING

Oral: 50–100 mg once daily.

Extended-release injection: 380 mg IM every 4 weeks; some patients may benefit from every 21 days

ADVERSE EFFECTS & MONITORING

Nausea, headache, dizziness; injection-site reactions with injectable formulation. Monitor liver enzymes after initiation and periodically.

KEY PRECAUTIONS

Do not use with opioids or when opioid pain medication is likely to be needed. Use caution with significant liver disease. Do not to use if liver enzymes are ≥10× the upper limit of normal.

Acamprosate| FDA-approved for AUD

First-line medication for AUD. Helps support abstinence and may reduce ongoing symptoms that follow alcohol withdrawal, such as insomnia, anxiety, or irritability. Consider using when the goal is abstinence, particularly after withdrawal. May be useful with liver disease because it is cleared by the kidneys.

HOW TO START

Start after withdrawal is complete and the patient has stopped drinking, if possible; adjust dose based on renal function.

TYPICAL DOSING

666 mg by mouth three times daily. Can be reduced to 333mg three times daily for patients with impaired kidney (renal) function.

ADVERSE EFFECTS & MONITORING

Diarrhea is most common; anxiety, insomnia, dizziness, and fatigue may occur.

KEY PRECAUTIONS

Do not use in severe renal impairment. Dose reduction is needed in moderate renal impairment.

Disulfiram | FDA-approved for AUD

Discourages alcohol use by producing an unpleasant reaction if alcohol is consumed. Consider using when the patient has a clear abstinence goal, particularly when dosing can be supervised. Effectiveness data are mixed.

HOW TO START

Confirm at least 12 hours since alcohol use; ensure the patient understands the alcohol-disulfiram reaction.

TYPICAL DOSING

Common dose is 250 mg daily; some patients may need a higher or lower dose.

ADVERSE EFFECTS & MONITORING

Fatigue, headache, dermatitis, metallic taste; uncommon risks include hepatitis and neuropathy. Alcohol-disulfiram reactions can include dyspnea, flushing, hypotension, nausea/vomiting, palpitations, sweating, and tachycardia. Monitor liver enzymes regularly.

Disulfiram | FDA-approved for AUD

KEY PRECAUTIONS

Patient must be abstinent before starting. Counsel about hidden alcohol in mouthwash, cough syrups, tonics, hand sanitizers, and other products. Avoid with advanced liver disease, clinically significant coronary artery disease, or known allergy; use caution with cognitive impairment.

Topiramate | Off-label; not FDA-approved for AUD

May reduce drinking days and heavy-drinking days. Consider using when first-line medications are ineffective or not tolerated; may also be helpful with a co-occurring seizure disorder.

HOW TO START

Begin at 25 mg once daily and increase slowly every several days to weekly as tolerated.

TYPICAL DOSING

Start around 25 mg daily and gradually increase; target doses up to 300 mg/day.

ADVERSE EFFECTS & MONITORING

Cognitive slowing, word-finding difficulty, paresthesias, dizziness, fatigue, weight loss, and taste changes.

KEY PRECAUTIONS

Use caution in patients with cognitive problems and/or renal impairment..

Gabapentin | Off-label; not FDA-approved for AUD

May help with post-withdrawal insomnia, anxiety, and cravings. Usually a second-line option, especially when sleep problems, anxiety, or ongoing withdrawal symptoms are prominent.

HOW TO START

Common approach is 300 mg at night or 300 mg three times daily, then increase over several days based on symptoms, sedation, and renal function.

TYPICAL DOSING

Often starts at 300 mg three times daily, with total daily dose adjusted according to response and tolerability.

ADVERSE EFFECTS & MONITORING

Dizziness, fatigue, sleepiness, poor coordination, and GI symptoms.

Gabapentin | Off-label; not FDA-approved for AUD

KEY PRECAUTIONS

Adjust dose for renal impairment; use caution because gabapentin can be misused.

TOOL 7.B: ALCOHOL WITHDRAWAL MANAGEMENT QUICK REFERENCE GUIDE

This resource is intended as a quick-reference guide and should not replace clinical judgment, supervision, or consultation with a qualified prescriber. Medication selection and dosing must be individualized based on patient-specific factors, current clinical guidelines, and organizational policies. Always verify dosing recommendations and treatment protocols using current approved sources before implementation.

Designed For: AFBSS programs and field-based clinical teams supporting individuals with alcohol use disorder who may be experiencing alcohol withdrawal.

How to Use: Use this tool to assess withdrawal severity, determine whether ambulatory withdrawal management is appropriate, identify monitoring needs, and recognize when referral to a higher level of care is required.

Recommended Users: Physicians, nurse practitioners, physician assistants, nurses, behavioral health clinicians, and other team members involved in withdrawal assessment, monitoring, and care coordination.

QUICK REFERENCE: WHAT IS ALCOHOL WITHDRAWAL?

Alcohol withdrawal is a clinical syndrome that occurs following the abrupt cessation or reduction of heavy and prolonged alcohol use after physical dependence has developed.

Under DSM-5, alcohol withdrawal is diagnosed when cessation or reduction in alcohol use is followed within hours to days by **two or more** of the following:

- ☐ Autonomic hyperactivity (sweating or pulse >100)
- ☐ Increased hand tremor
- ☐ Insomnia
- ☐ Nausea or vomiting
- ☐ Transient visual, tactile, or auditory hallucinations
- ☐ Psychomotor agitation
- ☐ Anxiety
- ☐ Generalized tonic-clonic seizures

Alcohol withdrawal can progress to seizures, delirium tremens, medical complications, and death if not recognized and treated appropriately.

Transfer to emergency or inpatient care if the patient develops:

- ☐ Seizure
- ☐ Hallucinations
- ☐ Confusion
- ☐ Delirium
- ☐ Worsening symptoms despite medication
- ☐ Persistent vomiting
- ☐ Severe agitation
- ☐ Unstable vital signs
- ☐ Syncope
- ☐ Over-sedation
- ☐ Worsening medical or psychiatric symptoms
- ☐ Inability to maintain hydration
- ☐ Return to heavy alcohol use during withdrawal management
- ☐ Inability to participate in follow-up

STEP 1: ASSESS WITHDRAWAL SEVERITY

Before beginning withdrawal management, assess:

- ☐ Time and amount of last alcohol use
- ☐ Previous withdrawal history
- ☐ Prior seizures or delirium tremens
- ☐ Current withdrawal severity (CIWA-Ar or SAWS)
- ☐ Medical and psychiatric comorbidities
- ☐ Concurrent sedative-hypnotic use
- ☐ Risk factors for complicated withdrawal

Consider laboratory testing when appropriate, but do not delay treatment while results are pending.

Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)

Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) is a clinician-administered tool used to assess alcohol withdrawal severity and guide treatment decisions. The CIWA-Ar can support identification of patients who may be appropriate for ambulatory management and those requiring a higher level of care.

Short Alcohol Withdrawal Scale (SAWS)

Short Alcohol Withdrawal Scale (SAWS) is a validated patient self-report tool that can be used to monitor alcohol withdrawal symptoms in ambulatory settings. The SAWS may be useful when daily follow-up is being conducted and can supplement clinician assessment, but it should not replace clinical judgment or evaluation of risk factors for severe or complicated withdrawal

STEP 2: DETERMINE WHETHER AMBULATORY MANAGEMENT IS APPROPRIATE

Appropriate for Ambulatory Withdrawal Management

Consider outpatient or field-based management when the patient:

- ☐ Has mild to moderate withdrawal symptoms
- ☐ Has stable medical and psychiatric conditions
- ☐ Can follow treatment instructions
- ☐ Can participate in follow-up
- ☐ Has a safe and stable environment
- ☐ Ideally has a reliable support person
- ☐ Does not have concurrent regular sedative-hypnotic use

All patients receiving ambulatory withdrawal management should receive:

- ☐ Education on expected symptoms
- ☐ Review of warning signs requiring urgent evaluation
- ☐ A low-stimulation environment
- ☐ Encouragement of hydration
- ☐ Nutrition support
- ☐ Sleep support
- ☐ Counseling on avoidance of alcohol and other sedating substances

Consider

- ☐ Daily multivitamin
- ☐ Thiamine 100 mg orally daily for 3 – 5 days

Refer for Higher Level of Care

Referral to emergency or inpatient care should be strongly considered when the patient has:

- ☐ History of or current severe or complicated withdrawal
  - Withdrawal seizures
  - Delirium tremens
  - Persistent hallucinations
- ☐ Significant confusion
- ☐ Syncope
- ☐ Unstable vital signs
- ☐ Active suicidality

- ☐ Serious or unstable medical conditions
- ☐ Worsening medical or psychiatric symptoms
- ☐ Progression of withdrawal symptoms despite medication
- ☐ Pregnancy
- ☐ Inability to tolerate oral medications
- ☐ Recurrent vomiting with inability to maintain hydration
- ☐ Significant sedative-hypnotic withdrawal
- ☐ Unsafe environment or unreliable follow-up

STEP 3: SELECT A MEDICATION STRATEGY & DOSAGE STRATEGY

Severity	Typical Approach
Very mild/mild withdrawal	Supportive care alone or medication (gabapentin or carbamazepine)
Moderate withdrawal	Benzodiazepines are first-line
Severe withdrawal	Higher level of care generally indicated

Medication Selection Considerations

Gabapentin or Carbamazepine

- May be appropriate for selected low-risk patients with mild withdrawal
- May not adequately prevent seizures or delirium in higher-risk patients

Chlordiazepoxide or Diazepam

- These long-acting benzodiazepines are common first-line options for moderate to severe alcohol withdrawal

Lorazepam or Oxazepam

- Shorter acting benzodiazepines that are less dependent on hepatic metabolism
- Preferred when there is concern for significant liver disease

Dosing Approaches

Symptom-Triggered Approach	Fixed-Dose Taper Approach

Medication is administered only when withdrawal symptoms reach a specified threshold.	Medication is provided on a predetermined taper schedule.
Advantages • Lower total medication exposure • Shorter treatment duration **Requirements** • Reliable symptom assessment • Close monitoring • Ability to recognize worsening symptoms • Duration of interval for reassessment and dose administered is dependent upon symptom severity	**Advantages** • Easier when symptom monitoring is limited • May be appropriate when patients cannot reliably self-assess **Considerations** • Regular reassessment is still required • Monitor for over-sedation

STEP 4: ESTABLISH A MONITORING PLAN

Recommended Follow-Up

Arrange **daily contact for up to five days after the last drink**, with in-person visits preferred when feasible.

Monitor During Each Follow-Up

- ☐ Return to use
- ☐ Withdrawal symptoms
- ☐ Vital signs
- ☐ Hydration status
- ☐ Mental status and orientation
- ☐ Sleep
- ☐ Mood and suicidality
- ☐ Medication adherence
- ☐ Emergence of complications

Telehealth may supplement in-person visits when clinically appropriate.

STEP 5: TRANSITION TO ONGOING AUD TREATMENT

Withdrawal management should be viewed as the beginning of treatment rather than the endpoint.

Before closing a withdrawal management episode, consider:

- ☐ Initiating medications for alcohol use disorder (e.g., naltrexone or acamprosate)
- ☐ Linking to behavioral treatment
- ☐ Connecting to recovery supports
- ☐ Establishing ongoing follow-up
- ☐ Developing a recurrence-prevention plan

Patients completing withdrawal management without ongoing AUD treatment remain at high risk for recurrence of alcohol use and future withdrawal episodes.

TOOL 7.C: MEDICATIONS FOR NICOTINE/TOBACCO USE DISORDER QUICK REFERENCE GUIDE

This resource is intended as a quick-reference guide and should not replace clinical judgment, supervision, or consultation with a qualified prescriber. Medication selection and dosing must be individualized based on patient-specific factors, current clinical guidelines, and organizational policies. Always verify dosing recommendations and treatment protocols using current approved sources before implementation.

Designed For: Quick reference to medications for smoking cessation.

How to Use: Compare medication options, dosing, monitoring, and precautions to support individualized treatment planning. Verify current prescribing guidance before use.

Recommended Users: Prescribers, nurses, pharmacists, and other clinical staff supporting tobacco cessation treatment.

Varenicline| FDA-approved for smoking cessation

First-line option. Partially activates nicotine-related brain receptors, reducing cravings and withdrawal while making smoking less rewarding. Often a strong single-agent option for adults who smoke, particularly when a simple non-nicotine option is preferred.

HOW TO START

Start 1 week before the quit date when possible.

TYPICAL DOSING

Days 1 to 3: 0.5 mg once daily.

Days 4 to 7: 0.5 mg twice daily.

Day 8 and on: 1 mg twice daily, if tolerated.

ADVERSE EFFECTS & MONITORING

Nausea, vivid dreams, and insomnia. Consider a lower dose if nausea is limiting.

KEY PRECAUTIONS

Severe renal impairment- dose reduction is needed.

Nicotine Replacement Therapy (NRT) | FDA-approved for smoking cessation

First-line option, particularly for patients wanting an over the counter or nicotine-based treatment. The patch gives a steady amount throughout the day, while gum or lozenges help with sudden cravings.

Nicotine Replacement Therapy (NRT) | FDA-approved for smoking cessation

HOW TO START

Can begin on the quit date or while cutting down. Apply a new patch each morning and rotate sites.

- **10+ cigarettes/day:** Start with 21 mg patch daily.
- **Fewer than 10 cigarettes/day:** Start with 14 mg patch daily.

Apply a **new patch each morning** and rotate application sites.

TYPICAL DOSING

If the patient continues to smoke on **21 mg/day**, the dose may be increased to:

- **35 mg/day:** one 21 mg + one 14 mg patch, **or**
- **42 mg/day:** two 21 mg patches**.**

A short-acting form such as gum, lozenge, or nasal spray can be used with the patch.

- **2 mg gum/lozenge:** if the first cigarette is more than 30 minutes after waking.
- **4 mg gum/lozenge:** if the first cigarette is within 30 minutes of waking.
- Use 1 piece every 1–2 hours as needed for cravings.

If the patient prefers to taper and cravings/withdrawal are well controlled, consider reducing the patch by 7 mg after 6 weeks (e.g., 21 mg → 14 mg).

ADVERSE EFFECTS & MONITORING

Patch: skin irritation, insomnia, vivid dreams. If insomnia or vivid dreams occur, remove at bedtime and reapply in the morning.

Gum/lozenge: mouth soreness, hiccups, nausea.

KEY PRECAUTIONS

Active cardiovascular disease is the primary precaution. NRT should be avoided in patients with unstable angina, life-threatening arrhythmias, and in the first two weeks after a myocardial infarction.

Data on NRT in pregnancy is limited; however, NRT is believed to be safer than continued smoking.

Similarly, data on NRT in adolescents is limited.

Bupropion | FDA-approved for smoking cessation

Acts on brain chemicals associated with nicotine dependence, reducing cravings and withdrawal and potentially helping mood symptoms. Reasonable first-line option when a non-nicotine medication is preferred or depressive symptoms are also present.

HOW TO START

Start approximately 1 week before the quit date when possible.

TYPICAL DOSING

Days 1–3: 150 mg each morning.

Day 4 onward: 150 mg twice daily, at least 8 hours apart.

Avoid bedtime dosing.

ADVERSE EFFECTS & MONITORING

Insomnia, dry mouth, anxiety.

KEY PRECAUTIONS

Avoid with seizure disorder or eating disorders.

TOOL 7.D: MEDICATIONS FOR OPIOID USE DISORDER QUICK REFERENCE GUIDE

This resource is intended as a quick-reference guide and should not replace clinical judgment, supervision, or consultation with a qualified prescriber. Medication selection and dosing must be individualized based on patient-specific factors, current clinical guidelines, and organizational policies. Sample protocols are available in Tool 7.E: Buprenorphine Initiation Checklist, but always verify dosing recommendations and treatment protocols using current approved sources before implementation.

Designed For: Quick comparison of medications and initiation approaches for OUD.

How to Use: Use alongside clinical assessment and shared decision-making to compare treatment options and initiation approaches, identify key implementation considerations, and guide next steps. Consult current prescribing information, clinical protocols, and organizational policies for detailed dosing and implementation guidance.

Recommended Users: Prescribers, nurses, pharmacists, clinical supervisors, and AFBSS care teams.

Buprenorphine| FDA-approved for OUD

Low-Dose Initiation With Opioid Continuation

Provides a gentler transition to buprenorphine and may allow initiation without requiring withdrawal before the first dose. The patient begins very small doses of buprenorphine while continuing a full-agonist opioid. Buprenorphine is gradually increased until a therapeutic dose is reached, then the full agonist is discontinued.

HOW TO START

Begin very low-dose buprenorphine while continuing the full-agonist opioid, then gradually increase buprenorphine over several days.

TYPICAL DOSING

Protocol-dependent. Sample **7-day** and **4-day** low-dose protocols; other rapid-overlap approaches may reach a full dose in about 3–4 days.

ADVERSE EFFECTS & MONITORING

Monitor the transition closely, including withdrawal symptoms and ongoing opioid use; overdose-prevention support is especially important.

KEY PRECAUTIONS

The full-agonist opioid must continue while buprenorphine is gradually increased. In ambulatory settings outside an OTP, this usually means continued use of non-medical opioids. There is currently no standardized low-dose initiation protocol, and the approach can be more complicated to explain and follow.

Buprenorphine | FDA-approved for OUD

High-Dose Initiation

May be useful when the patient is already in withdrawal and rapid symptom relief and treatment initiation are desired. Commonly used in emergency departments and urgent care settings but may also be used for unsupervised out-of-clinic initiation. The patient waits until withdrawal begins, then receives a larger initial dose of buprenorphine, with additional doses the same day if needed. Allows faster initiation and can help relieve withdrawal symptoms and begin treatment quickly.

HOW TO START

Confirm that withdrawal has begun before administering the initial buprenorphine dose; additional same-day doses may be given as needed according to the selected protocol.

TYPICAL DOSING

Protocol-dependent; Emergency Department Buprenorphine (Bup) Quick Start from the California Bridge to Treatment includes dosing recommendations.

ADVERSE EFFECTS & MONITORING

Studies found serious safety problems uncommon and precipitated withdrawal rare, including among people using fentanyl. Clinical monitoring should reflect the selected protocol and patient circumstances.

KEY PRECAUTIONS

The patient must be in withdrawal before starting. This approach may not be appropriate for everyone, particularly when complicating medical issues or sedation are present.

Buprenorphine | FDA-approved for OUD

Long-Acting Injectable Buprenorphine Initiation

Long-acting injectable buprenorphine is FDA-approved for moderate-to-severe OUD; initiation requirements and dosing are product-specific. Consider using when a long-acting medication may simplify treatment or better fit the patient's needs, preferences, and circumstances.

Buprenorphine | FDA-approved for OUD

Long-Acting Injectable Buprenorphine Initiation

HOW TO START

For patients not already taking buprenorphine, confirm objective withdrawal and give 4 mg sublingual buprenorphine. If tolerated, proceed with the product-specific injectable regimen. Patients already taking sublingual buprenorphine can transition according to product-specific conversion guidance.

TYPICAL DOSING

Brixadi®: after a tolerated 4 mg sublingual dose, 16 mg subcutaneous Brixadi®, followed by 8 mg within 3 days; an additional 8 mg may be given during the first week if needed.

Sublocade®: after a tolerated 4 mg sublingual dose, 300 mg subcutaneously; second 300 mg dose on days 8–28, then generally 100 mg monthly unless symptoms indicate continued or renewed 300 mg dosing.

ADVERSE EFFECTS & MONITORING

Some patients may require supplemental sublingual buprenorphine until steady-state levels are reached; monitor clinical response during the transition.

KEY PRECAUTIONS

Follow product-specific prescribing and conversion guidance. Brixadi® is available in weekly and monthly formulations and does not require refrigeration. Sublocade® is monthly and should be refrigerated, although it can remain at room temperature for up to 12 weeks after removal from refrigeration.

Buprenorphine | FDA-approved for OUD

Direct-to-Inject Buprenorphine Initiation

Direct-to-inject initiation without a sublingual lead-in as a newer approach with emerging evidence. The patient starts with an extended-release injectable form of buprenorphine rather than beginning with sublingual buprenorphine. May be an option when starting directly with a long-acting injectable could simplify treatment or better fit the patient and treatment setting.

HOW TO START

Follow an established direct-to-inject protocol appropriate to the medication, setting, and patient.

TYPICAL DOSING

Protocol-dependent. CA Bridge direct-to-inject protocols and USC Street Medicine 2-day and 3-day approaches.

Buprenorphine | FDA-approved for OUD

Direct-to-Inject Buprenorphine Initiation

ADVERSE EFFECTS & MONITORING

Some patients may continue to feel unwell or experience withdrawal symptoms after injection. Follow-up and supportive care are important. Early outpatient and community-based reports describe encouraging short-term follow-up and retention, but evidence remains emerging.

KEY PRECAUTIONS

This is a newer approach. Programs may need clear workflows, staff training, medication access, and reliable follow-up support before implementation.

Methadone | FDA-approved for OUD

Activates the mu-opioid receptor; at an adequate dose, reduces withdrawal and cravings and blunts the effects of other opioids. Reduces opioid withdrawal and cravings and supports treatment retention.

HOW TO START

Initiate through a federally certified OTP; start low and increase gradually with close monitoring, especially during the first 1–2 weeks.

TYPICAL DOSING

Maintenance varies; many patients require 60–100 mg/day or more.

ADVERSE EFFECTS & MONITORING

Constipation, sweating, sedation, sleepiness. Additional QTc monitoring may be needed with cardiac risk factors, interacting medications, or doses >100 mg/day.

KEY PRECAUTIONS

Overdose risk is highest early in treatment, particularly with rapid dose increases or combination with alcohol, benzodiazepines, or other sedating medications. Methadone can prolong QTc.

Methadone for ongoing treatment is provided through OTPs. Mobile methadone delivery has the potential to expand access to underserved populations and communities with high risks for overdose. In addition to traditional approaches of referral, engagement, and coordination with local OTPs, county staff are encouraged to partner with their OTPs to explore options for mobile methadone delivery.

Naltrexone | Extended-release injectable formulation FDA-approved for OUD

Supports recurrence prevention after withdrawal by blocking opioid effects if opioid use resumes. Consider using after withdrawal is complete, particularly for patients preferring a non-opioid treatment approach.

HOW TO START

Patient must complete withdrawal and no longer be physically dependent.

Wait ≥7–10 days after short-acting opioids and 10–14 days after long-acting opioids such as methadone or buprenorphine.

TYPICAL DOSING

Extended-release naltrexone: 380 mg IM every 4 weeks.

ADVERSE EFFECTS & MONITORING

Nausea, headache, dizziness, injection-site reactions. Monitor liver function; do not give if transaminases are >5× the upper limit of normal.

KEY PRECAUTIONS

Do not start during current opioid use or physical dependence because it can precipitate withdrawal. Use caution with significant liver disease. Overdose risk increases if opioid use resumes after treatment because tolerance is reduced.

TOOL 7.E: BUPRENORPHINE INITIATION CHECKLIST

This resource is intended as a quick-reference guide and should not replace clinical judgment, supervision, or consultation with a qualified prescriber. Medication selection and dosing must be individualized based on patient-specific factors, current clinical guidelines, and organizational policies. Always verify dosing recommendations and treatment protocols using current approved sources before implementation.

Designed For: AFBSS programs and field-based clinical teams supporting individuals with opioid use disorder who are considering or initiating buprenorphine treatment.

How to Use: Use this tool to understand available buprenorphine initiation approaches, identify potential advantages and limitations of each strategy, support shared decision-making, and determine which initiation model may best fit a patient's needs and circumstances.

Recommended Users: Physicians, nurse practitioners, physician assistants, nurses, behavioral health clinicians, outreach teams, care coordinators, and other professionals involved in OUD treatment.

QUICK REFERENCE: UNDERSTANDING BUPRENORPHINE

Buprenorphine is used for both treatment of opioid withdrawal and ongoing treatment of opioid use disorder.

Key characteristics include:

- **Partial Opioid Agonist:** Buprenorphine activates opioid receptors but to a lesser degree than full agonist opioids such as fentanyl, heroin, oxycodone, or methadone.
- **Ceiling Effect:** Unlike full opioid agonists, buprenorphine reaches a point where increasing doses do not continue to produce increasing opioid effects. This contributes to its favorable safety profile.
- **High Receptor Affinity:** Buprenorphine binds very strongly to opioid receptors. This allows it to reduce cravings, withdrawal symptoms, and the effects of other opioids.

Because buprenorphine can displace other opioids from the receptor, initiating treatment too early can cause **precipitated withdrawal**.

CHOOSING AN INITIATION APPROACH

When choosing an initiation strategy, consider:

- ☐ Patient goals
- ☐ Prior experiences with buprenorphine
- ☐ Concerns about withdrawal
- ☐ Fentanyl exposure
- ☐ Housing status
- ☐ Cognitive and executive function (to manage medication regimen)
- ☐ Ability to store medication safely
- ☐ Transportation and follow-up capacity
- ☐ Access to pharmacies or injection services
- ☐ Interest in long-acting treatment options (most appropriate for someone compromised in cognitive and/or executive function)

Several approaches are now used to initiate buprenorphine.

Approach	Best For	Key Considerations
Low-dose overlap	Patients concerned about withdrawal, fentanyl exposure, or prior difficulties starting buprenorphine	More complex instructions and continued opioid use during transition
High-dose initiation	Patients already in opioid withdrawal	Faster initiation but requires withdrawal to be present
Injectable transition	Patients interested in long-acting treatment	Requires access to injectable medication and follow-up
Direct-to-inject	Patients interested in simplified maintenance treatment	Newer approach with less implementation experience

Programs should offer multiple options whenever possible and use shared decision-making to determine the most appropriate approach.

Option 1: Low-Dose Initiation (Low-Dose Buprenorphine with Opioid Continuation)

How It Works

The patient begins with very small doses of buprenorphine while continuing to use opioids. Buprenorphine is gradually increased until a therapeutic dose is reached, at which point opioid use is discontinued.

Typical Timeline

- Usually 3 – 10 days
- Some rapid protocols reach full doses in approximately 3 – 4 days

May Be Helpful For

- Patients concerned about withdrawal
- Individuals with fentanyl exposure
- Patients who previously experienced precipitated withdrawal
- Individuals who prefer a gradual transition

Practical Considerations

- Full agonist opioids must continue during the transition.
- In ambulatory settings this often means ongoing non-medical opioid use during the overlap period.
- Overdose prevention education and naloxone access remain essential.
- This approach may be easier physically for patients but can be more complicated operationally.

Sample Protocols

Sample outpatient low-dose buprenorphine initiation protocols are available in the table below. However, because dosing protocols continue to evolve and should be tailored to individual patients and settings, readers should consult the original publications and current clinical guidance rather than relying on a single standardized protocol.

- Cohen SM, Weimer MB, Levander XA, et al. (2022). Low-dose buprenorphine initiation strategies for patients using opioids. *Journal of Addiction Medicine*
- Suen LW, Lee TG, Silva M, et al. (2022). Low-dose buprenorphine initiation ("microinduction") approaches in clinical practice.

	7-Day Low Dose Buprenorphine initiation with Opioid Continuation Protocol						
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine Dose	0.5 mg daily	0.5 mg twice daily	1mg twice daily	2mg twice daily	4mg twice daily	4mg three times daily	8mg twice daily
Film size	2mg	2mg	2mg	2mg	2mg	2mg	8mg
Morning Dose	0.5mg	0.5mg	1mg	2mg	4mg	4mg	8mg

	(1/4 2mg film)	(1/4 2mg film)	(½ 2mg film)	(1 film)	(2 films)	(2 films)	(1 film)
Afternoon Dose						4mg (2 films)	
Night Dose		0.5mg (1/4 2mg film)	1mg (½ 2mg film)	2mg (1 film)	4mg (2 films)	4mg (2 films)	8mg (1 film)
Full Agonist	Continue	Continue	Continue	Continue	Continue	Continue	Stop

	4-Day Low Dose Buprenorphine initiation with Opioid Continuation Protocol			
	Day 1	Day 2	Day 3	Day 4
Buprenorphine Dose	0.5mg (1/4 film) every 6 hours	1mg (1/2 film) every 6 hours	2mg (1 film) every 6 hours	12mg (1 film) in AM with provider follow up
Film Size	2mg	2mg	2mg	12mg
Full Agonist	Continue	Continue	Continue	STOP

Option 2: High-Dose Initiation (Withdrawal-First Approach)

How It Works

The patient waits until opioid withdrawal develops and then receives a larger initial dose of buprenorphine, often with additional doses on the same day if needed.

May Be Helpful For

- Patients already experiencing withdrawal
- Individuals seeking rapid symptom relief
- Situations where same-day treatment initiation is possible

Common Settings

- Emergency departments
- Urgent care settings
- Clinics
- Office-based treatment

- Patient self-start protocols

Practical Considerations

- Withdrawal must be present before initiation.
- Not every patient is willing or able to tolerate withdrawal.
- Clinical assessment remains important when significant medical or psychiatric concerns are present.

Sample Protocols

- Buprenorphine Emergency Department Quick Start
- Patient Self-Start for Buprenorphine (this can be printed and given to the patient).

Option 3: Initiation of Long-Acting Injectable Buprenorphine

How It Works

Long-acting injectable buprenorphine is administered subcutaneously and provides sustained medication levels without daily dosing.

Potential Advantages

- Reduced need for daily medication management
- Less frequent dosing
- Reduced concerns about medication loss
- Simplified treatment for some patients

Practical Considerations

- Some patients may require supplemental sublingual buprenorphine during transition.
- Administration requires appropriate storage, inventory, and injection workflows.
- Follow-up remains essential.

Sample Protocols

- Brixadi® Initiation**:** For patients not currently taking buprenorphine who have objective withdrawal, give 4 mg sublingual buprenorphine; if tolerated, administer 16 mg subcutaneous Brixadi®, followed by 8 mg within 3 days. An additional 8 mg may be given during the first week if needed. Patients already taking sublingual buprenorphine should be converted using the weekly or monthly dose chart found in the package insert.

- **Sublocade® Initiation:** For patients not currently taking buprenorphine who have objective withdrawal, give 4 mg sublingual buprenorphine; if tolerated, administer a 300 mg subcutaneous initial dose. Give the second 300 mg dose between days 8 and 28, then continue 100 mg monthly unless symptoms indicate the need to continue or return to 300 mg.

Option 4: Direct-to-Inject Approaches

How It Works

The patient begins treatment with a long-acting injectable buprenorphine product without first establishing treatment using sublingual buprenorphine. Emerging evidence suggests that direct-to-inject approaches are feasible and may be well tolerated for some patients. However, implementation experience remains more limited than with traditional initiation approaches.

Potential Advantages

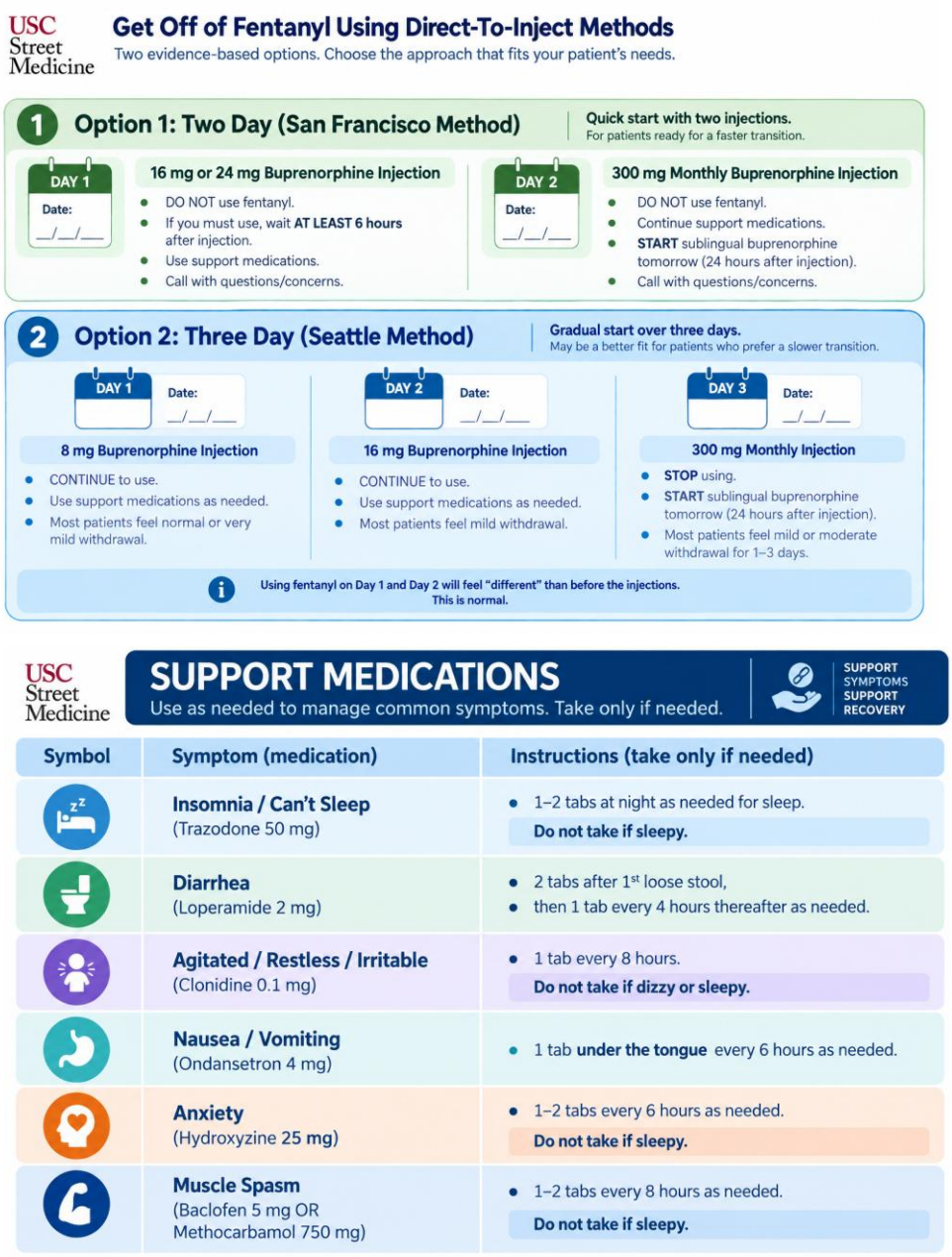
- Simplified treatment pathway
- Elimination of daily medication management
- Reduced risk of missed doses

Practical Considerations

- Requires access to injectable medication.
- Programs need clear workflows and staff training.
- Some patients may still experience withdrawal symptoms following administration.
- Close follow-up remains important.

Sample Protocols

- This Emergency Department Direct-to-Inject Buprenorphine from the California Bridge to Treatment includes protocols that have been used in emergency departments and facility settings.
- The resources below were adapted from USC Street Medicine and offers patients a 2-day or a 3-day option.



Adapted from: Cnop K, Zaks C, Collins S. *Innovations in Addiction Medicine on the Street: SUD Treatments for the Unhoused.* Presented at: American Society of Addiction Medicine (ASAM) Annual Conference; April 25, 2025; San Diego, CA.

FOLLOW-UP CONSIDERATIONS

Regardless of initiation approach, AFBSS teams should assess:

- ☐ Withdrawal symptoms
- ☐ Cravings
- ☐ Opioid use

- ☐ Medication adherence
- ☐ Side effects
- ☐ Overdose risk
- ☐ Naloxone access
- ☐ Engagement in ongoing treatment

TOOL 7.F: PHARMACOLOGIC TREATMENT FOR STUD

Disclaimer: Neither the Department of Healthcare Services (DHCS) nor Health Management Associates (HMA) is advocating for off-label medication usage in the treatment of StUD; however, we have included this information to encourage readers to be aware of what may be happening in the field and to monitor research developments in this area.

Designed For: Quick reference to pharmacologic approaches for StUD.

How to Use: Use to understand potential medication options, identify key prescribing and monitoring considerations, and support individualized clinical decision-making.

Recommended Users: Prescribers, pharmacists, nurses, clinical supervisors, and other clinicals involved in StUD treatment. Psychostimulants for StUD should generally be prescribed by clinicians with expertise in addiction medicine or addiction psychiatry.

There are currently no FDA-approved medications for stimulant use disorder (StUD), though some medications may benefit selected patients. Behavioral treatment remains the primary intervention, with medications used as an adjunct. Psychostimulants should generally be prescribed by clinicians with addiction expertise. Treatment should be individualized based on stimulant use, co-occurring conditions, goals, and follow-up capacity.

Potential off-label medications include:

- Bupropion.
- Extended-release injectable naltrexone + bupropion.
- Topiramate.
- Mirtazapine.
- Modafinil (selected cocaine use disorder).
- Long-acting psychostimulants in carefully selected patients.

Prescribing considerations

When medications are used:

- Monitor blood pressure and heart rate.
- Assess psychiatric symptoms.
- Evaluate diversion risk.
- Review your state's prescription drug monitoring program database (the Prescription Drug Monitoring Program (PDMP) in CA is the Controlled Substance Utilization, Evaluation and Review System, or CURES).

- Conduct urine drug testing when clinically appropriate.
- Reassess risks and benefits regularly.

Bupropion | Off-label; not FDA-approved for StUD

Increases dopamine and norepinephrine availability, partially replacing dopamine activity diminished by chronic stimulant use. May reduce cocaine use and amphetamine-type stimulant use, particularly with lower-frequency methamphetamine use. May be particularly useful with co-occurring depression or tobacco use disorder.

HOW TO START

Complete a comprehensive assessment and confirm no contraindications; may be started during active stimulant use if clinically appropriate.

TYPICAL DOSING

Extended-release formulations are typically titrated from 150 mg daily to 300–450 mg daily, depending on tolerability and treatment goals.

ADVERSE EFFECTS & MONITORING

Insomnia, anxiety, dry mouth, headache, tremor, nausea, hypertension. Monitor mood, anxiety, BP, sleep, adherence, and suicidal ideation, particularly during initiation.

KEY PRECAUTIONS

Contraindicated in patients with seizure disorders, anorexia nervosa, bulimia nervosa, or other conditions associated with increased seizure risk.

Extended-Release Injectable Naltrexone + Bupropion | Off-label; combination not FDA-approved for StUD

Naltrexone blocks mu-opioid receptors; bupropion increases dopamine and norepinephrine signaling. Together they may reduce craving and stimulant reinforcement. This combination has strong evidence for reducing methamphetamine use and improving abstinence among people with moderate-to-severe amphetamine-type StUD.

HOW TO START

Patient must be opioid-free before naltrexone. Bupropion is started orally while extended-release naltrexone is administered by intramuscular injection.

TYPICAL DOSING

Bupropion ER: 450 mg orally daily.

Extended-release naltrexone: 380 mg IM every 3–4 weeks.

Extended-Release Injectable Naltrexone + Bupropion | Off-label; combination not FDA-approved for StUD

ADVERSE EFFECTS & MONITORING

Nausea, headache, insomnia, anxiety, injection-site reactions, dizziness. Monitor liver function, mood, blood pressure, and confirm opioid-free status prior to each injection. Assess adherence to oral bupropion and monitor for depression or suicidal ideation.

KEY PRECAUTIONS

Do not administer naltrexone to patients currently using opioids or who remain physically opioid dependent. Bupropion remains contraindicated in seizure disorders and eating disorders.

Topiramate | Off-label; not FDA-approved for StUD

Enhances gamma-aminobutyric acid (GABA) activity while inhibiting glutamate neurotransmission, potentially reducing craving and the reinforcing effects of stimulant use. May be useful for cocaine or methamphetamine use, particularly among highly motivated patients; may also benefit co-occurring AUD.

HOW TO START

Initiate with a low dose and titrate slowly to improve tolerability.

TYPICAL DOSING

Usually titrated gradually to 100–300 mg daily in divided doses, depending on clinical response.

ADVERSE EFFECTS & MONITORING

Cognitive slowing, difficulty concentrating, paresthesias, fatigue, dizziness, appetite suppression, weight loss. Monitor weight, nutritional status, cognitive function, renal function, and bicarbonate when clinically indicated.

KEY PRECAUTIONS

Use caution with cognitive impairment, kidney stones, metabolic acidosis, underweight, or malnutrition.

Mirtazapine | Off-label; not FDA-approved for StUD

Enhances noradrenergic and serotonergic activity and blocks histamine receptors. Evidence is described as strongest for methamphetamine use disorder; may be useful with depression, anxiety, insomnia, or poor appetite.

Mirtazapine | Off-label; not FDA-approved for StUD

HOW TO START

Usually administer at bedtime because of sedating effects.

TYPICAL DOSING

15–45 mg orally at bedtime..

ADVERSE EFFECTS & MONITORING

Sedation, increased appetite, weight gain, dry mouth, constipation. Monitor mood, weight, appetite, daytime sedation, and suicidal ideation.

KEY PRECAUTIONS

Sedation may increase vulnerability among individuals sleeping outdoors or in unsafe environments. Weight gain may be beneficial in patients experiencing malnutrition. However, consider whether this is the right medication to offer to patients who may have limited access to food, as it may increase appetite.

Modafinil | Off-label; not FDA-approved for StUD

Promotes wakefulness through modulation of dopamine, glutamate, GABA, and other neurotransmitter systems. May be useful for cocaine use, particularly among patients without co-occurring AUD.

HOW TO START

May be initiated during active cocaine use if clinically appropriate.

TYPICAL DOSING

200–400 mg each morning..

ADVERSE EFFECTS & MONITORING

Headache, anxiety, insomnia, nausea, decreased appetite. Monitor sleep, anxiety, blood pressure, psychiatric symptoms, and adherence.

KEY PRECAUTIONS

May reduce the effectiveness of hormonal contraceptives. Generally avoid with active psychosis or history of stimulant-induced psychosis.

Long-Acting Prescription Psychostimulant | Off-label; not FDA-approved for StUD

Examples include long-acting methylphenidate, extended-release mixed amphetamine salts, and lisdexamfetamine.

Provides controlled dopaminergic stimulation that may reduce cravings and illicit stimulant use and stabilize reward pathways. May reduce cocaine or methamphetamine use; may be particularly helpful with co-occurring ADHD.

Long-Acting Prescription Psychostimulant | Off-label; not FDA-approved for StUD

Examples include long-acting methylphenidate, extended-release mixed amphetamine salts, and lisdexamfetamine.

HOW TO START

Generally only by clinicians with addiction medicine or addiction psychiatry expertise after careful risk-benefit assessment.

TYPICAL DOSING

Medication-specific; doses may need to be at or above those typically used for ADHD to reduce stimulant use..

ADVERSE EFFECTS & MONITORING

Increased heart rate, elevated blood pressure, insomnia, appetite suppression, weight loss, anxiety. Closely monitor blood pressure, heart rate, weight, sleep, appetite, medication adherence, urine drug testing (when clinically indicated), PDMP reviews, pill counts, and evidence of diversion or misuse.

KEY PRECAUTIONS

Use caution in patients with cardiovascular disease, uncontrolled hypertension, active psychosis, stimulant-induced mania, or significant diversion risk. Extended-release formulations are preferred because they have lower misuse potential.

EMERGING THERAPIES

Several medications are being actively investigated as potential treatments for stimulant use disorder. Although early research is promising, these therapies ***are not*** currently recommended as standard treatment, and additional randomized controlled trials are needed to establish their safety, effectiveness, and appropriate role in clinical practice. At this time, these medications should generally be considered investigational or reserved for specialized clinical settings, and they should not replace evidence-based behavioral interventions such as contingency management.

GLP-1 Receptor Agonists | Not FDA-approved for StUD; investigational

May reduce reward-seeking behavior by modulating mesolimbic dopamine pathways. Preliminary observational evidence suggests possible reductions in craving, overdose, and substance-related healthcare utilization.

HOW TO START

Investigational.

TYPICAL DOSING

Medication-specific weekly injections.

GLP-1 Receptor Agonists | Not FDA-approved for StUD; investigational

ADVERSE EFFECTS & MONITORING

Nausea, vomiting, weight loss, GI upset. Monitor weight, nutritional status, GI symptoms, and metabolic parameters.

KEY PRECAUTIONS

Not a routine StUD treatment; use caution with food insecurity or malnutrition.

Ketamine | Not FDA-approved for StUD; investigational

May enhance neuroplasticity and reduce cue-induced craving. Early trials, primarily in cocaine use disorder, suggest possible reductions in craving and recurrence; evidence remains limited.

HOW TO START

Investigational.

TYPICAL DOSING

No standardized StUD dosing; investigational protocols vary.

ADVERSE EFFECTS & MONITORING

Dissociation, elevated blood pressure, nausea, urinary symptoms with repeated use. Requires monitoring of blood pressure, mental status, respiratory status, and treatment response.

KEY PRECAUTIONS

Not recommended for routine clinical use outside research or specialized treatment programs.