CENTER FOR HEALTH & JUSTICE AT TASC

Ensuring an Effective SUD Service Network

Nine Components of a Robust Community Service Network

This brief is intended to aid local planning groups, community leaders, and their partners in collaborative efforts to expand community-based substance use treatment and related service capacity. It presents nine components of a robust and effective service delivery network.

A robust, effective community-based substance use disorder (SUD) service delivery network means that residents can access a continuum of high-quality treatment and other services.[1] TASC's Center for Health and Justice has identified the following nine critical service domains comprising such a network, with examples of services or programs delivering them.

Components of Community-based SUD Treatment Capacity

1. Person-Centered Care Coordination: This domain comprises services that assertively, reliably, and knowledgably coordinate and manage the variety of care and services being received by community members. A robust community SUD service system should ensure this type of assistance to help individuals access the care they need and navigate the broad service system, which often includes addressing systemic, cross-system, and other barriers. Coordination is best maintained by case managers who build meaningful and consistent relationships with individuals throughout the evolution of client service experiences rather than transitioning clients to new case managers each time they shift into or out of any set of services. When this ideal is not possible, communities should ensure that case managers communicate with all relevant providers and/or other case managers to ensure seamless transitions of care.
2. Life-Saving Services: This domain comprises services that are, by their nature, immediately accessible and responsive to life-threatening or otherwise serious crises. Examples include crisis stabilization centers (facilities that provide acute care for individuals in crisis), administration of naloxone (the medication used to reverse opioid overdose and prevent death), and syringe access (to prevent transmission of communicable diseases during injection drug use). Communities should ensure that hospitals, SUD service providers, and first responders—including police, fire fighters, and

emergency medical technicians—are aware of overdose symptoms and the use of naloxone to reverse it. Stakeholders may wish to ensure provision of training on naloxone administration to first responders, and that they have it in their possession.

Many overdoses occur in the home, in the company of family, friends, and other people using drugs. Accordingly, it is critical to ensure that individuals with opioid use disorder (OUD) and their friends and family know how to identify overdose, have naloxone in their possession, and know how to use it. Several states have issued standing orders for naloxone, allowing anyone to purchase it at a pharmacy without an individualized prescription. Communities may wish to consider making overdose education and naloxone training broadly available, akin to CPR training; making naloxone quickly accessible in public environments, such as shopping centers or schools, similar to defibrillators; and equipping individuals at high risk for overdose, and their friends and families, with naloxone free of charge. Individuals who have abstained from use—including those departing a controlled environment such as jail, prison, withdrawal management services, and sometimes residential treatment—are at significantly elevated risk of return to use and overdose death.[2,3,4] Because of their unique position to distribute naloxone to individuals with OUD and to their families or friends upon release or discharge, communities may wish to work with their state prisons and local jails, hospitals, and residential treatment providers to facilitate distribution of naloxone to individuals with OUD—and to their families and friends—upon release.

Making Naloxone Readily Available in the Community

Automated External Defibrillators (AEDs) are located in public places, and many people are trained in Cardiopulmonary Resuscitation (CPR). Communities have invested in these measures because they save lives when available the moment they are needed. Ensuring immediate access to naloxone for overdose reversal is a similar approach. Check with local public health departments or other community-based organizations who distribute it to determine accessibility. Some communities have placed naloxone in libraries and high schools, equipped first responders, and dispensed it to people leaving correctional settings and their loved ones.

Communities may also wish to consider advocating "Good Samaritan" laws (or, if they are already in place, promoting awareness of them or working to reduce barriers to their use and effectiveness). These laws, which have been adopted in some form by over 40 states and the District of Columbia, are intended to incent people to seek emergency medical care for friends or family who are overdosing when doing so may expose the caller to risk of being criminally charged for illicit drug possession or other charges. They usually provide a caller limited immunity from prosecution for specific criminal charges.[5]

3. Withdrawal Management: This domain comprises services that manage symptoms of withdrawal from certain substances (also sometimes referred to as "detox"), reducing risk of serious complications, and relieving pain and discomfort. The clinical need for these services is determined by which substances an individual is using, and by his or her constellation of symptoms and overall health status. Withdrawal management services help stabilize individuals who wish to practice abstinence in their recovery and prepare them to engage in longer-term treatment, but alone are insufficient to address SUD. In fact, individuals withdrawing to abstinence from opioids face significantly elevated risk for overdose and death due to decreased physical tolerance.[6] FDA-approved SUD medications and other intensive treatment options have been shown to stabilize individuals and reduce this risk, and communities should consider how to make them broadly accessible (see next section).

   To monitor and ease physical symptoms of withdrawal syndrome, a robust SUD service system must ensure a variety of opportunities for withdrawal management, available for selection based on clinically determined need and individual preference. Services should be available in inpatient, residential, and outpatient settings.

4. Medication: Ensuring access to an array of medications, including access to all approved by the U.S. Food and Drug Administration (FDA) for OUD, is critical in a robust SUD service delivery system. Currently there are three: methadone, buprenorphine, and naltrexone. *Methadone* is an agonist

medication, binding to opioid receptors in the brain in a controlled, safe manner to stop withdrawal and prevent cravings. *Buprenorphine* is a partial agonist medication, working in a manner similar to methadone, but activating the opioid receptors less strongly. *Naltrexone* is an antagonist medication, blocking instead of binding to the brain's opioid receptors, preventing the euphoric effects of any opioids in the system. People who are physiologically tolerant to opioids will not feel euphoria, intoxication, or sedation when receiving properly dosed methadone or buprenorphine. They do not need to withdraw from opioids prior to induction, whereas individuals receiving naltrexone do. The introduction of naltrexone requires withdrawal first; for people who have not already withdrawn, naltrexone will precipitate it. (In addition to their use as part of maintenance treatment, methadone or buprenorphine may be used as part of withdrawal management tapering regimens.)[7,8,9]

Medication-assisted treatment (MAT), which involves medication along with counseling, has been shown to be effective in supporting recovery and preventing risk of overdose and death. Researchers have found fewer overdose deaths among those who took methadone or buprenorphine following a non-fatal overdose than those who did not.[10] Because each medication has a unique benefit and risk profile, and is dispensed differently, clinicians should work with individuals to decide which medication is clinically indicated, appropriate, accessible, and desired. The decision to use medication and which medication to use is clinical, and should be made in consultation with a clinical professional based on an individual's history, health, and needs, and—as with any other medical care—should be respectful of an individual's preferences.[11] Some experts are now calling for a "medication-first" approach to treat OUD, which emphasizes timely access to maintenance medication without requiring psychosocial services or discontinuation for any reason other than client harm.[12]

Many individuals need medications beyond just those that treat SUD; prevalence rates of co-occurring SUD and mental health conditions such as anxiety disorders (such as generalized anxiety, panic disorder, and post-traumatic stress disorder) and serious mental illness (such as major depression, bi-polar disorder, and schizophrenia) are high. Numerous studies have demonstrated that about half of those experiencing an SUD will experience mental illness in their lifetime, and vice versa.[13,14,15]

Medications for SUD Treatment

Medications for SUD treatment are an especially useful tool in treating opioid use disorder (OUD). As part of an overall treatment plan, FDA-approved medications may reduce or eliminate cravings that can lead to relapse.

Views about SUD medications vary widely. They are used—and viewed—as a mechanism to support safe withdrawal, an ongoing treatment for a chronic disease, and as a harm reduction strategy. They have been proven as evidence-based practice and are, for many, a cornerstone of their recovery. However, some unsupported beliefs persist, such as the idea that use of medication simply substitutes one addiction for another and enables SUD. Misperceptions and ideological opposition are not founded on evidence, and may well be dangerous, given that they can lead to denial of access to medications shown to help reduce relapse, overdose, and death.

Communities should consider eliminating "abstinence only" treatment, services, or criminal justice programs that limit how long individuals receive medications or prohibit their use altogether, or expand treatment that does not apply "abstinence only" limits. They also may wish to create opportunities to educate capacity expansion partners and other stakeholders about MAT's effectiveness and work to dispel myths, increase acceptance, and develop a shared understanding and language that consider SUD medications a lifesaving treatment option.

5. Behavior Change Services: This domain comprises a variety of evidence-based services that are effective for people with SUD across a range of modalities including inpatient, residential, intensive outpatient, and outpatient treatment services, along with cognitive behavioral therapy and mindfulness practices. They can provide a foundation for ongoing recovery and self-efficacy beyond initial stabilizing and other therapeutic services. Communities should ensure that a broad array of behavior change services are accessible to individuals receiving other SUD services whose recovery would benefit from them.

6. Medical Care: Individuals with SUD have higher rates of chronic medical conditions, including hepatitis C, mental illness, asthma, and hypertension.[16] Treating the whole person means also

addressing needs outside of those directly related to SUD. Medical care includes primary, preventive, and specialty care services that are responsive to the specific needs of people with SUD.

7. Family and Children's Services: SUD affects not only individuals, but also their families, friends, and communities. Because family members often provide critical support to individuals receiving treatment and engaging in and maintaining recovery, services that support the family and children are also important.
8. Housing: This domain comprises a continuum of housing services ranging from emergency housing (e.g., shelters) to longer-term options. Housing needs vary greatly by person, and a housing network must be responsive to the individual's unique needs, including desired location. For example, permanent supportive housing may be a fit for individuals who are chronically homeless and have high needs, whereas interim housing may be useful and in demand for people returning home following incarceration. Housing must also be affordable, stable, and accommodating of family when applicable. Stakeholders should contact local housing authorities to learn more about what is available and to engage them in the planning process.
9. Recovery Support Services: This domain comprises community-based supports that can help individuals move toward and remain in recovery, such as twelve-step programs and "Winner's Circle" peer-support community groups. Recovery supports also include faith-based organizations, transportation assistance, vocational training or education, and job placement services, reflecting that recovery occurs in and among the community.

About TASC's Center for Health and Justice

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

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

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For further information, or to learn about CHJ's consulting and training services, contact:
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Endnotes

[1] For further discussion of what constitutes an effective behavioral health service delivery system, see SAMHSA's 2011 brief, *Descriptions of a Good and Modern Addiction and Mental Health Service System,* available at https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf.

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[11] For more information about SUD medications, see SAMHSA's medication-assisted treatment page at https://www.samhsa.gov/medication-assisted-treatment as well as their publication, "TIP 63: Medications for Opioid Use Disorder: Resources Related to Medications for Opioid Use Disorder, For Healthcare and Addiction Professionals, Policymakers, Patients, and Families," at https://store.samhsa.gov/system/files/sma18-5063pt5.pdf. Also, see ASAM's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf.

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