CENTER FOR HEALTH & JUSTICE AT TASC

Substance Use Treatment Capacity Expansion

Aligning Treatment Resources to Meet Demand

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 through realignment of resources to meet demand. It defines treatment capacity, articulates key strategies and planning considerations for expansion, presents critical questions to inform capacity assessment, and identifies common barriers and innovative solutions.

Introduction

Limited or inaccessible community-based treatment and supportive services for substance use disorder (SUD) is an ongoing and growing concern at municipal, county, and state levels across the country. Stakeholders from government, treatment providers, the community, and other sectors face shared challenges with regard to assuring sufficient capacity of their treatment service networks. Cross-sector collaboration provides opportunity for change that is mutually beneficial to partners and the community.

Addressing SUD treatment capacity requires challenging a common, standard narrative that treatment is non-existent, too costly, too far away, or otherwise unavailable. While such concerns may well be true, accepting this narrative often overlooks and underutilizes resources (e.g., services, funding, or staff) that are ineffectively aligned with community demand.

Aligning existing resources involves assessing current capacity; identifying and removing barriers to access; establishing policies, processes, and procedures that allow greater access to and movement between services; and developing services to fill gaps within a provider network. The process reallocates resources configured by unexamined legacy decisions to optimize the response to current demand.

It is crucial that stakeholders develop and maintain a shared language to most effectively and efficiently respond to their community's demand for critical opioid and other SUD services as partners each bring unique perspectives and expertise to the table, enriching interdisciplinary planning processes.

Defining Treatment Capacity

"Treatment capacity" refers to the totality of community-based SUD services in a community, as measured by both the quantity and quality of services available across an array of nine key service domains *(see companion Brief: "Ensuring an Effective SUD Service Network").* Effective treatment capacity requires an interconnected SUD service system that includes a robust network of person-centered services that are accessible, affordable, and available on demand. It is reinforced by assuring service provision that is non-discriminatory on race, ethnicity, gender identity, or ability to pay.

Treatment capacity should support both initial and ongoing recovery efforts by ensuring comprehensive, integrated, wraparound services that address the whole person and not just his or her immediate SUD needs. Individuals should be able to enter into and move between different treatment levels and modalities and across services regardless of where they start. While there can be a seemingly natural order to progression between service levels and types, recovery may not reflect a linear process, and it is not unusual for individuals to move back and forth between them, return to services they have previously utilized, or simultaneously access multiple types of services offered by different providers.

A community's treatment capacity affects not only its preparedness and ability to meet the need for opioid and other SUD treatment, but also individuals' ability to engage in desired services.

Key Strategies for Expanding Treatment Capacity

There are two main strategies to expand community-based SUD treatment capacity:

1. Maximizing Use of Existing Capacity through Realignment: Capacity can be increased by realigning resources to meet community demand—removing barriers to care, coordinating existing resources to better serve individuals, and expanding existing services or infrastructure, such as physical space, administration, or billing support. For example, adding an additional counselor to an outpatient practice that is in-network with Medicaid could allow more flexibility with scheduling and a greater number of available appointments. Further, adding ambulatory withdrawal management to services offered by an outpatient provider of SUD medications rather than shifting resources from one to the other could facilitate care for greater numbers of individuals with diverse needs.
2. Building New Capacity: Creating new services to fill gaps in the existing service network also may increase capacity. To create new services, communities can explore and leverage funding opportunities—both short-term (e.g., to invest in physical space for service delivery) and long-term (e.g., to investing in staffing or client services)—via any number of funding sources such as local health foundations, state and local revenues, federal grants, and tax levies.

This brief focuses on the first strategy—maximizing use of existing capacity. With infrastructure already in place, working to maximize use of existing capacity is often a quicker way to facilitate improved access to care and services.

Expanding Treatment Capacity: Planning Considerations

Capacity expansion efforts should consider several important issues during the planning process. First, they should ensure that their community's programs and practices reflect a current scientific understanding about the nature of SUD. Stakeholders and partners (treatment providers, community members, hospitals, law enforcement, and others) should work to develop a shared understanding of SUD as chronic in nature, and recognize that treatment and recovery processes are highly individualized and may include return to use. Additionally, they should work to ensure that evidence-based and promising-practice services are accessible. Communities can use SAMHSA's Evidence-based Practices Resource Center to access information on such services (www.samhsa.gov/ebp-resource-center).

Further, capacity expansion efforts are strengthened when mutual recognition is developed among planning partners that clinical decisions should be made by qualified, trained clinicians, and that individuals' autonomy should be respected. Partners should work to ensure that individuals' treatment, service, and support needs are assessed both initially and intermittently on a continuing basis, and that treatment and services are matched to each individual's unique identified needs. There is no one-size-fits-all approach.

Harm Reduction Strategies

Many communities have incorporated *harm reduction* strategies into their community responses to SUD. These efforts aim to mitigate the negative consequences associated with drug use, even when individuals continue using. Harm reduction strategies may include naloxone distribution to prevent fatal overdose, syringe access programs to reduce transmission of infectious disease, low-threshold treatment and recovery housing that does not impose unrealistic admission requirements, and other practices. Communities should apply these and other harm-reduction strategies to their capacity expansion efforts.

Critical Questions: Assessing Community Capacity and Demand

Communities can begin or inform capacity expansion work by considering the following critical questions, which serve as a preliminary aid in considering and pursuing capacity expansion efforts. (Comprehensive planning and implementation requires a deeper and broader process.)

These questions, organized into four groups, are intended to spur discussions that yield and highlight important information related to a community's current capacity, current demand, how well resources are aligned with demand, and to what extent care coordination is embedded. Depending on where a community is in a planning process, specific questions may merit more or less attention.

1. Treatment Capacity: Treatment capacity is measured by both the quantity and quality of services available in a community across an array of service domains *(see companion Brief: "Ensuring an Effective SUD Service Network")*. Communities can identify local SUD services using the Substance Abuse and Mental Health Services Administrations (SAMHSA) Behavioral Health Treatment Services Locator (www.findtreatment.samhsa.gov), other state- or region-specific resource directories, and through local recovery communities.

   An important first step in maximizing existing capacity is to assess it. By establishing a comprehensive overview of current resources and limitations, this process helps inform decisions about what services to prioritize for building capacity later on.

   (a) What and how much treatment capacity exists in the community?

   (b) Are existing services person-centered, high-quality, effective, and responsive to individual needs?

   (c) Who is served by these providers and agencies, and who is not (e.g., accepted forms of insurance, geographic area, and specific minority and vulnerable populations such as transgender, criminal justice, or homeless individuals)?

   (d) Which services are at capacity?

   (e) Which services have underutilized or unused capacity?

2. Accessibility: Accessibility, a key feature of capacity, refers to the practical matter of finding and engaging in services. Service characteristics that impact accessibility include hours of operations (especially evening, holiday, and weekend accessibility, which is important for facilitating treatment on demand and accommodating work, childcare, and other time conflicts for continued engagement in services), cultural and language competencies, prior authorization requirements set forth by insurance carriers, intake processes, geographical proximity, and access to transportation. Services that exist but are inaccessible are not likely being maximized.

   (a) How do people (families, clients, first responders, providers, and others) learn about services?

   (b) How do they access services?

   (c) How do they move between different types of services?

   (d) If there is a care coordination process, what is it?

3. Demand: The goal of capacity expansion efforts should be to meet the *demand* for services, which is distinct from the perceived or assessed *need* for services. Not everyone referred or screened for services may utilize, want, or even need them. Treatment capacity expansion based solely on a quantified need for services—for example, based on the prevalence of SUD in a community—may fail to result in anticipated utilization, leave newly created capacity unused, result in the loss of resources invested in expansion, and leave the impression that the community can never achieve the "needed" level of funding. This should not be interpreted to mean that communities ought to abandon efforts to encourage individuals who may need treatment to engage in it. Instead, meeting demand can be viewed as an initial step in capacity expansion. Should a community succeed, it could then decide to further expand capacity as it seeks to engage a greater portion of those who need treatment in it. The goal of expansion through treatment capacity alignment is to meet the community demand. As demand grows, capacity will need to grow to accommodate rising demand.

   Assessing a community's demand for SUD services will help identify gaps in the treatment network, thereby informing realignment and other expansion efforts to identify opportunities for maximizing

current and building new capacity. This work may involve exploring referral sources or the demand of specific special populations to understand current and potential entry points to treatment, such as self-referral, emergency departments, law enforcement, courts, and other justice system agencies. Assessing demand requires a fact-based assessment of whether or not there is truly a *capacity* problem, or if the problem is instead the *accessibility* of treatment for certain populations and timeliness of access. This must be revisited regularly, as drug use trends change and treatment strategies and treatment modalities evolve, shifting demand for specific services.

(a) What is the demand for SUD services in the community (as measured, for example, by the length of a waitlist or the number of people on the list who eventually engage in care)?

(b) What is the gap between existing treatment capacity and individuals' interest in services?

(c) Which services or types of services do individuals request?

(d) What discrepancies exist between demand and clinically indicated need?

(e) Where is treatment, and where are clients? Is there geographic accessibility?

4. Stakeholders: Stakeholders are the core of collaborative planning processes and should include, at a minimum, community planning teams, treatment and supportive/wraparound service providers (e.g., housing or employment assistance), law enforcement and other first responders, and community members (e.g., individuals with lived experience and their family/friends). Early and ongoing stakeholder engagement is critical to incorporate the variety of unique and meaningful perspectives and expertise among members, which enhances the planning process.

   Communities should prepare for common stages of systems change processes, including initial excitement for the new initiative; realities of systems change such as high demands and expectations of partners; and the point at which the initiative maxes out and the community requires new resources to move the work forward.

   (a) What stakeholders are engaged in treatment capacity planning conversations?

   (b) Who else might be brought to the table?

   (c) What ongoing community planning processes relate to SUD treatment capacity, and is there a way to streamline efforts?

   (d) Does inclusion of certain stakeholders require accommodation, such as payment for travel or time (e.g., individuals with lived experience or others who are not participating in a professional capacity)?

Capacity Expansion: Common Barriers and Innovative Solutions

Capacity expansion efforts fundamentally involve identifying barriers and implementing solutions that address them. Several common barriers that often impede such efforts are presented below, along with examples of initiatives that have applied innovative solutions to overcome them.

1. Inaccessibility: Limited or nonexistent services and lack of available and reliable information about existing treatment capacity for families, clients, providers, and the community may result in capacity that is underutilized or inaccessible, creating a problematic gap in a community's SUD treatment service network. Other practical barriers to accessing services may include lack of transportation, limited hours of operation that interfere with work or childcare requirements, and language barriers, each of which should be considered during treatment capacity planning discussions.

   After identifying what types of accessibility challenges they face, communities can approach them through measures designed to address each (e.g., the development of a public awareness campaign or website promoting local treatment, investment in case management to help individuals navigate the system, creation of a provider consortium to build interagency awareness and collaboration, providing transportation assistance, or offering mobile treatment or telehealth services).

2. Limited access to SUD medications*:* Lack of available SUD medication options in the community can be detrimental to recovery for many who could benefit from this critical treatment. Communities may wish to educate eligible prescribers and service providers about the array of FDA-approved SUD medications and their efficacy, and about how to become a prescriber or provider. This could include, for example, leveraging recent changes to federal regulations designed to expand buprenorphine prescribing waiver limits for physicians and expansion of prescribing authority to nurse practitioners and physician's assistants.[1,2]

   Communities can explore advocating educational campaigns to overcome misperceptions about SUD medications or policy changes designed to reduce practical barriers to their use. They may also want to consider encouraging coordination and partnerships between prescribers and other service providers and referral sources to ensure greater continuity of care and increased support for inclusion of medications into individual treatment plans when indicated and desired.

3. Health Insurance: Challenges associated with insurance largely affect service networks and relate not only to individual coverage but also to payer requirements. For many individuals without experience and knowledge of how to use insurance, successful enrollment and redetermination (required periodically to maintain enrollment and coverage) necessitate assistance of navigators or others familiar with enrollment systems and deadlines. Redetermination can be especially challenging among certain populations, such as individuals without stable housing services and those who are incarcerated, who are unlikely to receive mailed notifications.

   Beyond enrollment and maintenance of coverage, requirements instituted by managed care organizations in both Medicaid and private insurance systems can present challenges to accessing sufficient care. For example, pre-authorization requirements for certain services and medications frequently involve lengthy waits for determination decisions, thus delaying service engagement. Length-of-stay requirements may arbitrarily limit treatment to inadequate dosages. Insufficient reimbursement rates deter agencies and providers from participating in the Medicaid program or other managed care networks, resulting in challenges to create adequate networks of services that match clinical need and demand.

   Treatment Capacity and the ACA

   The availability and accessibility of health insurance is an evolving landscape and continues to be a key part of legislative conversations at both federal and state levels. Ongoing challenges to the Affordable Care Act's (ACA) requirement that plans include behavioral health care as "essential benefits" in all plans threaten to undermine the broad-scale inclusion of substance use and mental health care services to millions of Americans, and enforcement of federal parity requirements (that mental health and substance use disorder benefits are comparable to coverage for general medical and surgical care) remains a challenge to access. Communities may wish to reach out to local, state, and national policymakers to advocate insurance policies that remove barriers to care for individuals with SUD.

   Communities should consider focusing on enrollment of as many individuals as possible in health coverage—public or private—and on engaging covered individuals in existing services for which their insurer will pay to meet their assessed need for and interest in such services. Providers can also evaluate the use of existing resources (e.g., treatment slots) and explore whether joint funding is an option to cover care or as bridge funding while waiting for insurance authorization.

   - House Bill 1 (Illinois, 2015)
     Illinois approved House Bill 1, also known as the Heroin Crisis Act, in 2015. The Act required that insurers adopt medical necessity standards for substance use treatment set by the American Society of Addiction Medicine (ASAM), required that insurers remove prior authorization requirements for FDA-approved SUD medications, and authorized a standing order for naloxone to enable trained pharmacists to dispense the lifesaving medication.[3]
   - Senate Bill 3 (New Jersey, 2017)
     In 2017, New Jersey approved Senate Bill 3, which banned prior authorization requirements for inpatient and outpatient SUD services when deemed medically necessary by an authorized clinician. It also required that out-of-network providers take action to admit an

individual into services within twenty-four hours when no in-network hospital service provider is immediately available, and also that insurers provide unlimited inpatient or outpatient SUD treatment at in-network facilities.[4]

4. Funding: Public funding allocated in a manner that is disproportionate to resource demand can create a burden on services essential to a complete and robust treatment system. Solutions may involve, for example, seeking diversified funding (both public and private), advocating for or proposing county budget reallocations, or authorizing and enacting levies to support development and sustainability of SUD services. One example of a community funding solution follows:

    - Bernalillo County, NM
      In response to a greatly deteriorated behavioral health care infrastructure largely related to a state Medicaid audit that disrupted operations and service delivery, Bernalillo County (Albuquerque) was not well-positioned to leverage Medicaid expansion to support service provision to individuals with SUD. As such, the county collaborated with local and national partners to develop a Behavioral Health Business Plan detailing the challenges and opportunities of the behavioral health service landscape. The plan has guided the targeting of dedicated revenue from a voter-approved gross receipts tax, generating approximately $18 million a year, towards the development and support of behavioral health services across the county. To date, initiatives implemented or in development using GRT revenue include a jail reentry center, mobile crisis teams, supportive housing, a LEAD program and a crisis stabilization center, along with other projects.

5. Restrictive Administrative/Front-door Policies: Service providers and other stakeholders may have policies that hinder immediate access to treatment and services, as clients are turned away or told to waid, leaving existing capacity unused. Often, these barriers were implemented to serve a practical purpose, such as a requirement for medical clearance hinging on bloodwork or tuberculosis test prior to intake in order to prevent medical crisis or spread of infectious disease. Other administrative barriers may include requirements for abstinence, recent drug use (as a proxy indicator of disorder), daily phone calls while on a wait list, or possession of an official identification card. Of particular concern are policies that restrict justice-involved individuals from program eligibility, which may limit treatment options after release from incarceration, the period during which individuals are especially vulnerable to overdose and death.

    With service providers at the table, local planning groups may wish to consider the benefits and challenges posed by policies like these to ensure treatment is accessible and being used in an efficient and effective manner. In some cases, screening for co-occurring serious mental illness or other complex medical needs is necessary, since they may confound care plans, require a greater level of care, or generate practical concerns or liabilities for providers. Even with focused efforts, some providers may be unable or unwilling to modify their policies. Bringing decision-makers and line staff with on-the-ground knowledge into these conversations may increase opportunities to align policies with demand for services and optimize the use of resources.

6. Intake Availability: Sometimes services are not readily accessible at the time of referral or request for treatment. This is particularly challenging for first responders trying to make referrals following an overdose reversal or crisis de-escalation, since these events occur around the clock and on weekends and holidays when many providers do not have intake availability. Establishing cross-agency and cross-system partnerships, formalizing inter-agency referral processes, and evaluating entry points to care lay the groundwork for developments of warm hand-offs to services and access to treatment on demand. Several examples of a community's intake solution follow:

    - A Way Out, Lake County, IL
      Lake County's "A Way Out" program is a self-referral deflection program in which individuals can appear in person at any participating police station or sheriff's office and request substance use treatment. The program was developed collaboratively and across sectors, by local law enforcement, the State's Attorney's office, treatment providers, and community members. In the program, individuals who ask to participate are briefly screened via phone

by the Lake County Health Department (usually within 24 hours, and often more quickly than that) and linked with an appropriate SUD treatment provider for further assessment. If applicable, they are not subject to criminal charges for possession of illicit substances or paraphernalia in their possession. The program currently is expanding to additional police departments across the county, and is growing opportunities to connect people to care by permitting telephone participation requests.[5]

- AnchorED, Rhode Island
  Anchor Recovery Community Center trains and certifies peer coaches to meet individuals at hospital emergency departments following an overdose. Coaches provide patients with education and resources about SUD and treatment, and follow up with them after their release to encourage engagement in treatment services. Available at all 12 hospitals across Rhode Island, preliminary findings indicate greater treatment engagement.[6]

Conclusion

SUD treatment capacity is more than just quantity of services. Rather, sufficient treatment capacity assures a constellation of effective services, delivered holistically and in a coordinated manner, broadly accessible on-demand to those who want and need them. Efforts to increase treatment capacity can begin with a collaborative process among community stakeholders to maximize current resources and better align them to meet demand, guiding immediate and long-term expansion efforts.

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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Endnotes

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[5] Addiction Policy Forum. (2017, April). *Spotlight: A Way Out Lake County, Illinois*. Retrieved from https://cdn2.hubspot.net/hubfs/4132958/bfe1ed_a889a5914db24ffeb3bce439b18c2fca.pdf. A Way Out is a member of the Police Assisted Addiction and Recovery Initiative (PAARI). For more information, see https://paariusa.org/.

[6] Addiction Policy Forum. (2017, February). *Spotlight: AnchorED Rhode Island*. Retrieved from https://www.addictionpolicy.org/hubfs/AnchorED.pdf.