Improve Access to Evidence-Based Treatment
Substance use disorders can look very different from one person to another, and there is no single silver bullet treatment that works for everyone. As the science behind treatment continues to improve, however, there are two things we can say with certainty.

First of all, there is a basic need to extend access to evidence-based care. The treatment most substance use disorder patients receive today is simply ... nothing. Only 1 in 10 SUD patients receive care at a specialized treatment facility. Most individuals with SUDs are never referred to treatment, and for those 1 in 10 who are referred, many find that they are not offered a full range of treatment options. For certain vulnerable or institutionalized groups, such as pregnant women and prison inmates, access to treatment of any kind is particularly difficult.

Second, the need for an individualized and adaptable approach provides the common thread for interventions that effectively treat SUDs. Funders should be wary of any single approach that claims to have cornered the market on effective treatment, eschews all other interventions, and places the burden of failure solely on the “readiness” (or lack thereof) of a patient. High-quality, evidence-based treatment is not any single therapy, but the practice of drawing upon the full spectrum of what we know works. In practice, that means integrating clinical expertise, patient values and preferences, and research evidence into the decision-making process for patient care. Evidence-based tools (sometimes called treatment modalities) include different types of talk therapy, incentives for reduced use, medications to reduce cravings, versions of 12-step therapy, and many more. In addition, many of these can be combined for a more-tailored fit. Case managers, for instance, can help patients access and balance the treatments that are right for them. Availability of a particular treatment is often unrelated to the strength of evidence for that treatment. For example, while evidence for the effectiveness of medication-assisted treatment is much stronger than that for the effectiveness of 12-step programs, the latter are much more widely available within treatment centers.

It’s like getting the same antibiotic for a [drug]-resistant infection—eight times. – SUD patient who cycled in and out of 12-step-based treatment programs without being offered other treatment options.
This section outlines four opportunities to change this situation, getting more people access to the treatment they need. The first two strategies focus on breaking the cycle of substance use by extending care to populations with particularly high barriers to care. The second two strategies work to ensure greater access to specialized treatment for the general population.

**Breaking the cycle for high-risk groups**

Drug and alcohol use during pregnancy can put a woman at risk of potentially fatal complications, and can increase the risk that a baby is born too soon or with a health complication. Many women are afraid to seek prenatal care or admit their substance use, fearing that they will be judged by care providers, faced with criminal charges, or even separated from their existing children. Once children are born, parental substance use increases the risk of child abuse and neglect, as well as the risk that the child will go on to develop an SUD.

While many would not think of inmates as a vulnerable population, incarceration makes it difficult to access treatment—not just within the prison, but in the community after release. This is a population with high need; approximately 6 in 10 U.S. inmates have a substance use disorder, exacerbating the challenges they face upon release and making recidivism and its accompanying costs to society all the more likely. Recently released individuals with SUDs are also at elevated risk of fatal overdose, as they may return to substance use without realizing that abstaining during incarceration has lowered their tolerance. For those individuals, the dose that used to get them high is now deadly.

- **High-impact opportunity: Help pregnant women, mothers, and their young children get the help they need**
  The most effective programs for women are residential, offer gender-specific programming, involve children and families, and provide housing and comprehensive support services. Such interventions can help women recover from their SUDs, gain parenting skills to strengthen their family, and retain/obtain custody of their children. They also ensure that newborns get the care they need to minimize harm from substance exposure and that young children receive specialized support. However, such intensive programming is expensive to provide and, therefore, rarely available to low-income women. To find out more and learn how philanthropy can help low-income mothers and families move toward recovery, turn to page 26.

- **High-impact opportunity: Break the cycle of substance use and incarceration by connecting inmates with the care they need**
  Low-income individuals in many states rely on Medicaid, which in most states is terminated during incarceration but can be renewed upon release. However, the difficulty in re-enrolling can present a major barrier to care. Connecting pre-trial detainees, current inmates, and formerly incarcerated individuals with Medicaid allows them to access mental health care, including SUD treatment, seamlessly upon re-entry into the community. This care can keep them alive and on track to recovery and a fresh start. Moreover, the concurrent reduced recidivism and lower health care costs can result in cost-savings to taxpayers. To find out more and learn how philanthropy can support increased treatment enrollment and reduced recidivism, turn to page 28.
Improve screening, early intervention, and access to mental health care for the general population

Primary care and the emergency department are the most common points of care for most Americans, but physicians are often underequipped to identify, treat, or manage substance use disorders. There are two simple strategies that can help. Health care providers can check early-onset SUDs before a full-blown condition develops through effective Screening and Brief Intervention and can deliver specialized evidence-based treatment through Collaborative Care models.

• High-impact opportunity: Improve screening and early intervention for SUDs

There is a simple protocol that allows health care providers to quickly identify risky or problematic substance use, intervene briefly if appropriate, and refer patients to more intensive treatments when warranted. Patients answer a few screening questions about use. For those who report risky use, the care provider follows up with a brief discussion about the risks of use and the options for cutting back. Finally, the provider gives a referral to treatment for those whose use is severe enough to warrant treatment. This is known as SBIRT (Screening, Brief Intervention, and Referral to Treatment), and it has shown promise in reducing alcohol use and related negative outcomes such as drunk driving and sexually transmitted infections. Moreover, studies have shown that every dollar spent on SBIRT can generate cost savings in health care of between $3.80 and $5.60. Excitingly, it’s also a promising avenue for research into SUD prevention among adolescents, a particularly high-risk group for new SUDs. To find out more about how philanthropy can improve screening and early intervention through SBIRT, turn to page 30.

• High-impact opportunity: Integrate mental health care, including SUD treatment, with primary care

Originally developed for treating depression and mental health conditions, the Collaborative Care model is characterized by the following: care teams deliver evidence-based, patient-centered care; health care providers track outcomes for their entire patient population; and care providers are reimbursed for patient outcomes rather than volume of services provided. Collaborative Care can improve mental health and other risk factors for SUDS and, in some implementations, can directly improve access to quality SUD care. There is also a high potential for cost savings. In one study, every $1 spent on this strategy generated $6.44 in health care savings. To find out more and learn how philanthropy can help capacity-building efforts in Collaborative Care, turn to page 32.

All of the opportunities in this section offer innovative approaches to improve access to effective SUD treatment. They extend much-needed care to population groups often unable to access quality care or improve the screening and treatment processes currently offered by mainstream health care providers. These strategies benefit individuals in need of better treatment and also provide savings to taxpayers by reducing associated health care costs.
Help pregnant women, mothers, and their young children get the help they need

Among pregnant women aged 15 to 44 in the U.S., 1 in 20 are current illicit drug users\(^{136}\) and 1 in 13 report using alcohol.\(^{137}\) Children of mothers who abuse drugs and alcohol are at increased risk for a variety of problems, and the mothers themselves have a higher likelihood of experiencing trauma or abuse.\(^{138}\) Drug and alcohol use during pregnancy can lead to negative effects on the baby, including congenital anomalies and an increased risk of developing an SUD in the future.\(^{139, 140}\)

**CORE PRACTICE:** Residential programs specifically designed for pregnant women and their children offer gender-specific and trauma-informed treatments, providing comprehensive support services for the entire family.

**Target Beneficiaries:** Low-income pregnant women and mothers with SUDs, along with their young children

**Impact:** Participants in these comprehensive, tailored programs showed reductions in substance use and improved birth outcomes, with increases of 20-30 percentage points in the rate of babies born full term or at healthy weights.\(^{141}\) There can also be impacts on important related factors, such as parenting skills and whether or not a child is placed in state custody. Compared with mothers in regular treatment programs, mothers treated in these tailored, family-based programs are twice as likely to be reunited with their child.\(^{142}\) While the available data are not sufficient to yield a confident prediction about second-generation prevention, these improvements have the potential to reduce the biological and environmental factors that increase a child’s risk of developing a future substance use disorder.

**Cost-per-impact profile:** Costs vary by location, but implementer Meta House (see following page) requires $6,750 in philanthropic funding (leveraging additional public funding) to provide a pregnant mother, newborn, and additional young child with three months of specialized treatment. Potential impacts include a threefold increase in the mother’s likelihood of remaining abstinent from drugs and alcohol for at least six months after her child’s birth (from around 25% to around 80%), a reduced risk of low birth weight and prematurity for babies born to mothers in treatment, and increased likelihood that mothers with children in foster care can be reunited with their children.\(^{143}\)

**HOW PHILANTHROPY CAN HELP:** Organizations like Meta House rely on philanthropy to fill gaps in public funding, enabling women to access the treatment they need for as long as they need it. For example, Milwaukee County currently covers 75 days of a woman’s treatment at Meta House; other sources of funding are often needed to extend treatment until a woman has successfully transitioned out of the program.

---

I’ve learned about how using drugs covered up the hurt I was feeling ... I feel so much more [now], and it’s painful but a blessing and a joy. I’ll never forget when the baby first kicked. I’m already getting to know her – I know when she’s hungry or wants to sleep.

— Arielle, former cocaine user, mother of 2, graduate of Meta House\(^{134}\)

I needed time. I didn’t know how long it was going to take. I knew I needed TLC for a longer period than I would get at a traditional rehab. I was sick, I was really, really sick.

— Katie, former cocaine and heroin user, mother of 1, graduate of Meta House\(^{135}\)
Meta House

Meta House has been treating women with SUDs in Milwaukee, WI, since 1963. Women and children at Meta House are a high-risk, high-need population, with disproportionately low education, high unemployment, and frequent homelessness. Over 90% of women at Meta House have suffered trauma or abuse. To serve this population, Meta House’s residential program provides a wide range of comprehensive services for up to 35 women and 20 children at a time, including gender-specific and trauma-informed care. For example, while many treatment models emphasize a patient’s powerlessness over drugs or alcohol, Meta House women—having experienced powerlessness throughout their lives—often need a sense of empowerment to change their behavior.

Another key component of Meta House’s model is the space for children. It was one of the first treatment centers in the country to allow children to stay in treatment with their mothers. They offer child-specific services, such as filial play therapy, in which therapists coach mothers and help support healthy child development through playtime. They also offer parenting education and ways to engage fathers and father figures, such as through a Father Engagement Specialist or Family Nights.

Impacts for mothers at Meta House include increased abstinence from alcohol and illicit drugs and healthier birth outcomes for babies. Women who participated in treatment also reported 33% fewer days of experiencing mental illness symptoms. At intake, approximately 15% of Meta House women with minor children were living with those children. Six months after treatment, however, almost half (48%) of the children of Meta House women had either remained in their mother’s care, been reunited with their mothers, or had increased visitation.

TIPS

Best practices for comprehensive mother and family care include:

- Case management
- Individual, family, and group therapy
- Safe housing for women and children in their care
- Services for children (e.g., play therapy, academic assistance)
- Medical, mental health, and prenatal care
- Parenting education and coaching, including individual instruction about infant care
- Education & support for additional family members

TAKE ACTION

To support Meta House, visit their website at www.metahouse.org. To find similar programs in your community, see our website for recent grantees from SAMHSA’s Services Grant Program for Treatment for Pregnant and Postpartum Women (www.samhsa.gov/grants/gptra-measurement-tools/csac-gpra/csac-gpra-mmprw), which have been recognized as high-quality programs. Or, use the program criteria listed in our tips (at right) to identify a similar program in your community.
### Core Practice

**Helping detainees and people on criminal justice supervision enroll or re-enroll in Medicaid allows them to access mental health treatment (including SUD care) immediately upon release, reducing the risk of fatal overdose and facilitating successful re-entry into the community.**

**Target Beneficiaries:** Individuals who are involved in the criminal justice system, either as detainees (pre-trial) or inmates. Approximately 60% of this population has a SUD.

**Impact:** Improved access to evidence-based treatment for detainees and inmates, which likely leads to reductions in fatal overdose, recidivism, and their associated costs. Research from the state of Washington found that improving treatment access for justice-involved individuals with a history of substance use disorder can slow health care spending for that population, resulting in overall health care cost savings of $1,944 per member per year.

**Cost-per-impact profile:** The Healthy & Safe Communities Initiative of the ACLU of San Diego and Imperial Counties (see next page), a leading implementer, operates on a budget of approximately $120,000 per year. In their first year of operation, they have facilitated Medicaid enrollment for over 2,100 individuals, with approximately 200 more awaiting enrollment decisions. This translates to a philanthropic cost of $50-$60 per enrolled individual. That cost per enrollee will continue to decrease with time, as the greatest investment of time and money is in the up-front costs to develop and pilot the enrollment strategy. In addition, as noted above, similar efforts in Washington state returned nearly $2,000 in health care cost savings per individual.

**How Philanthropy Can Help:** Funders who want to increase access to care and reduce recidivism can fund capacity-building to help organizations like the ACLU of San Diego and Imperial Counties extend their services and share what they’ve learned about what works.
Healthy & Safe Communities Initiative of the ACLU of San Diego and Imperial Counties

The Healthy and Safe Communities Initiative (HSCI), facilitated by the ACLU of San Diego and Imperial Counties, works to increase Medicaid enrollment among individuals who are incarcerated, formerly incarcerated, or under criminal justice supervision. The HSCI is comprised of local community clinics, reentry service providers, and advocacy organizations. The HSCI collaborates with the local Sheriff’s, Probation, and Health and Human Services Departments to identify mechanisms to make Medicaid enrollment smoother for re-entry or release, minimizing dangerous interruptions of care.

From July 2014 to April 2015, the program connected over 2,100 re-entering individuals (approximately 65% of whom have an SUD) with health care coverage through Medicaid. Over 230 additional individuals are currently in the process of enrollment (as of April 2015).148

The HSCI operates on a budget of approximately $120,000 per year, which includes funding for a full-time staff attorney to lead the project and the part-time costs of supporting staff. The project is entirely philanthropically funded; funders have included the Open Society Foundations, the California Endowment, and the Parker Foundation.

In addition to providing technical assistance to the Medicaid enrollment project, HSCI works to reform the systems that influence care within and outside of the correctional system.149 For example, recent projects include:

• Developing toolkits for working with law enforcement on Medicaid enrollment programs
• Coaching to other initiatives engaged in similar efforts
• Working with advocates across the country to support policies that increase access to care, such as allowing inmates to make an appointment with a community care provider before release

Future work will include impact evaluation to help understand exactly how Medicaid coverage affects the way these populations access care, as well as continued capacity-building efforts around the country. The Initiative plans to work towards systemic change to increase access to care, including advocating for Medicaid-funded supportive housing and specialized Medicaid programs for individuals with SUDs.

TIPS

Funders looking to support changes to criminal justice systems can look for advocates with strong connections to state and local decision-makers. As the HSCI example illustrates, sometimes small, technical changes can be powerful solutions, but it’s difficult to identify those opportunities without an inside perspective on the way systems and administrative barriers work.

TAKE ACTION

To support the Healthy & Safe Communities Initiative, visit their website at www.aclusandiego.org. Other organizations whose work includes SUD treatment access for prison populations are the Legal Action Center and COCHS, profiled on pages 40-41 of this guide.
High-impact opportunity 2.3

**Improve screening, prevention, and early intervention for SUDs**

Primary care and the emergency department are the most common points of care for most Americans, but health care providers in both settings are underequipped to identify, treat, or manage substance use disorders. Less than 20% of primary care providers (PCPs) feel “very prepared” to identify the condition, and most patients with SUDs say their PCP did nothing to address their substance abuse. The result? Risky alcohol and drug use goes undiagnosed and unchecked, opening the door to a full-blown disorder and all of the negative impacts that follow.

**CORE PRACTICE:** All patients in hospital emergency departments, primary health clinics, or other health care settings automatically undergo a quick screening to assess their alcohol and drug use. If their use puts them at risk of developing a serious problem, they receive a brief intervention that focuses on raising their awareness of their substance use-related risks and motivating them to change their behavior. Patients who need more extensive treatment receive referrals to specialty care. The entire process is known as SBIRT (screening, brief intervention, and referral to treatment).

**Target Beneficiaries:** Individuals with risky substance use behaviors or SUDs receiving care from a hospital, primary care clinic, or other non-specialized setting

**Impact:** SBIRT can reduce drinking and the risky behaviors that often come along with it. Patients receiving SBIRT have reduced drinking by 13-34% compared with controls. As drinking drops, so do consequences associated with risky drinking. Patients who received SBIRT have shown significant reductions in hospital days and emergency department visits over the four years following the intervention. Of 100 emergency-department patients who screen positive for risky alcohol use, on average 28 will require another emergency-department visit in the following year. But if they receive SBIRT, the likelihood decreases by 38% to about 17. A recent implementation in New York City found that risky drinkers who received SBIRT were 23% less likely to acquire new sexually transmitted infections. There is also some evidence that SBIRT could decrease marijuana use. Finally, proponents of SBIRT point out that simply identifying the disorder is valuable for the provider seeking to manage a patient’s overall care.

**Cost-per-impact profile:** A cost-benefit analysis of a hospital-based program found that each dollar spent on SBIRT would generate $3.81 in savings from consequent reductions in both emergency department visits and hospital admissions, while other reviews have found savings as high as $5.60 per dollar spent.

**HOW PHILANTHROPY CAN HELP:** Primary care clinics and hospitals may be willing to implement SBIRT, but making the change isn’t easy. Things like billing systems and patient intake need to be adjusted, and these changes need to occur without disrupting current patient care. Philanthropists can fund the training, technical assistance, and organizational development support needed for an implementation to be successful. They can also fund pilots and new research into SBIRT in non-medical settings such as schools, for high-priority populations such as adolescents, and on less-studied substances such as marijuana.
The Institute for Research, Education, and Training in Addictions (IRETA) and NORC at the University of Chicago

The Institute for Research, Education, and Training in Addictions (IRETA) and NORC at the University of Chicago specialize in delivering these capacity-building services, enabling more care providers to offer SBIRT—and allowing more patients to reap the benefits. They provide up-front capacity-building, such as training for health care providers, as well as ongoing support and coaching to ensure that SBIRT is implemented effectively. To successfully implement SBIRT in a hospital or clinic, staff need to be trained and the accompanying systems—e.g., patient intake protocols and medical billing codes—need to be adjusted as well.\textsuperscript{161, 162}

For more on SBIRT to prevent SUDs in adolescents, see page 47.

TAKE ACTION
Donors interested in supporting SBIRT capacity in their communities can work directly with local care providers or can contact IRETA or the NORC via their websites at www.ireta.org and www.norc.org. IRETA is also a great resource for donors interested in supporting research into new applications of SBIRT, for example, among adolescents.

High-impact opportunity 2.4

Integrate mental health care, including SUD treatment, with primary care

While it is not always clear which illness causes the other, substance users often experience symptoms of another mental illness, and mental illness can increase vulnerability to drug abuse. In 2013, 7.7 million adults—nearly 40% of all SUD sufferers—also had another co-occurring mental disorder. Treatment for mental health issues, including substance use disorders, has historically been separated from other kinds of medical care. That separation creates barriers for patients and reduces the quality of care, often while increasing health care costs. Health care reform efforts will encourage care providers to integrate SUD treatment and other mental health services into their practice, but many physicians need assistance to effectively implement a more integrated care model.

CORE PRACTICE: Mental health and SUD treatment are provided seamlessly alongside primary care and managed by trained care teams, which include primary care providers and behavioral health specialists. This allows a medical practice to reach more patients with the full spectrum of needed care, improving outcomes and reducing medical expenses.

Target Beneficiaries: Individuals with mental health issues, including SUDs, who receive care from a hospital, primary care clinic, or other non-specialized setting

Impact: Evidence shows that integrated care improves outcomes for mental health disorders such as depression and anxiety, known to be risk factors and common co-diagnoses for SUDs. For example, Collaborative Care is a particular model of integrated care in which care teams deliver evidence-based, patient-centered care; track health outcomes for their entire population; and are reimbursed for patient outcomes rather than volume of services provided. In a randomized controlled trial of 1,801 patients with depression, Collaborative Care patients were three times more likely to have complete remission of their symptoms (25% vs. 8% of control group) and over twice as likely to have their symptoms reduced by 50% or more. Collaborative Care’s impact on SUDs is less well-studied, but early evidence is promising. For example, one randomized study of traumatic injury survivors admitted to a hospital found that Collaborative Care was associated with decreases in alcohol consumption. Given that patients with anxiety or depression have double the likelihood of an SUD, Collaborative Care can, at minimum, improve mental health among patients with both conditions and will ideally strengthen mental health care overall and help SUD patients achieve recovery more often and more quickly.

Cost-per-impact profile: In the initial trial, researchers found cost-savings of $3,363 per Collaborative Care patient per four years, compared with treatment as usual. Savings came from reduced expenses on outpatient mental health, pharmaceuticals, other outpatient care, and hospital-based care, generating up to $6.44 in related health care savings per dollar invested.

HOW PHILANTHROPY CAN HELP: As with SBIRT (p. 30), health care providers may be willing to make the change to integrated care, but logistics and administrative barriers can be daunting. Philanthropists can fund the training, coaching, and organizational development support needed for a medical practice to successfully implement integrated care. These implementations can also be great research opportunities, improving the field’s understanding of what works in integrated care and what impact it can have on SUDs specifically.

Collaborative Care has now been convincingly shown to meet the “triple aim” of health reform, including improving quality of care, patient satisfaction, patient symptoms and functional outcomes with either no increase in costs or reduced costs.

– Wayne Katon, M.D., University of Washington School of Medicine

Lifting the Burden of Addiction: Philanthropic opportunities to address substance use disorders in the United States
AIMS at the University of Washington

The AIMS (Advancing Integrated Mental Health Solutions) Center is a research center at the University of Washington dedicated to helping organizations put the Collaborative Care model into practice. To this end, AIMS engages in three kinds of activity: coaching and support to health care organizations seeking to implement Collaborative Care, workforce training in integrated care, and research on new populations and settings.

An engagement between AIMS and an organization implementing Collaborative Care—a network of health clinics, for example—proceeds as follows:

- **Lay the groundwork:** Help the clinic develop a clear vision and plan for its implementation of Collaborative Care, including hiring plans and necessary changes to relevant protocols.
- **Develop patient-tracking approach:** Population-based care—Collaborative Care team tracks outcomes over the full patient population—is a core principle of Collaborative Care. To do this, providers need a registry that continuously tracks all patients’ progress toward clinical outcome goals.
- **Train the workforce:** Effective Collaborative Care creates a team in which all of the providers work together on a single treatment plan for each patient. For example, if a new mother meeting with her primary care provider exhibits signs of post-partum depression, the primary care physician can connect her to a therapist who is part of the care team. The physician and therapist then work together to come up with a plan that addresses the patient’s medical needs along with her mental health needs. AIMS provides training for each role and helps the implementer fit these roles into the broader organization.
- **Launch and sustainability:** AIMS provides tailored coaching and support to clinics and organizations post-launch to help them achieve long-term sustainability in terms of team functionality, quality improvement, and finances. A critical component is teaching clinics how to use outcome measures to determine if stated goals are being met and, if not, how to make adjustments.

The full process typically takes 12-36 months.

**TAKE ACTION**

Funders interested in improving integrated care capacity can work directly with local care providers or can contact AIMS via their website at www.aims.uw.edu for more information.

**TIPS**

Because clinics’ needs vary so widely, there is no “typical” case. However, existing projects can provide useful examples of Collaborative Care implementation. For example, an implementation of Collaborative Care in eight rural primary care clinics is expected to provide better mental health care for approximately 8,000 adults at a cost of $750 per patient. The project is funded by a $2M Social Innovation Fund grant, which was matched by the John A. Hartford Foundation. Each clinic was then required to match its award.