Treatment Capacity: Divert to What?

Catching Up with COSSAP, April 2020 Edition

Law enforcement and first responder diversion offers a connection to treatment and recovery for individuals with substance use disorders (SUDs). But before a system for referrals can be implemented within a community, the local availability and variety of treatment must be assessed in order to establish treatment capacity. Put another way, assessing treatment capacity answers the question, "Divert to what?"

Treatment capacity refers to the totality of community-based SUD services in a community, measured by both the quantity of and accessibility to those services.[1] Common concerns voiced when communities begin to catalog treatment and services are that they're nonexistent, too costly, too far away, or otherwise unavailable. Although these are valid concerns, focusing on them exclusively may result in the underutilization of *existing* resources that are ineffectively aligned with community demand. This challenge can be mitigated by encouraging cross-sector collaboration that may provide opportunities for change that are mutually beneficial to both stakeholders and the community.

When designing a first responder led-diversion program, treatment capacity should be one of the first topics on the planning agenda. Key stakeholders involved with the diversion program should conduct an environmental mapping of their community to identify existing resources and means to access them. Stakeholders should include community planning teams, treatment and supportive/wraparound service providers (e.g., housing or employment assistance), first responders, and community members (e.g., individuals with lived experience and their families/friends), in addition to local treatment providers. The goal of assessing treatment capacity is to meet the community's demand for services by determining the levels and types of care most frequently required, as determined by the clinical assessment process.

Key questions to ask when assessing treatment capacity are:

a. What and how much treatment capacity (e.g., outpatient treatment providers, withdrawal management services, medication-assisted treatment options, etc.) exists in the community?

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

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

d. Which services are at capacity?

e. Which services have underutilized or unused capacity?

Keep in mind: not everyone requires the highest level of care, such as residential treatment, although often this becomes a default referral. Levels of care range from residential treatment to outpatient services; types of services may include medication-assisted treatment, cognitive-behavioral counseling, and recovery housing, to name only a few.

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First responders will want to work with community treatment providers to review an historical snapshot of demand for their services prior to implementing a diversion program in order to anticipate demand. Diversion partners also need to consider the length of time needed to access these services—from time of referral to intake into the treatment program—as first responders may require immediate access to services depending on whether they are referring individuals in crisis or conducting non-crisis, post-overdose site visits.

Before expanding treatment capacity (e.g., opening a new outpatient treatment center), a community should maximize the use of services that *already* exist. Resources can be realigned to meet the demand for services and streamline access to them. For example, by coordinating with a treatment provider to facilitate a law enforcement/first responder drop-off process, individuals can be more quickly and directly diverted to treatment instead of being brought to the emergency department or detained for lack of other options. Such collaboration may include setting aside a certain number of beds for individuals diverted by law enforcement/first responders or having a designated person triage an individual's need for services.

After a first responder-led diversion program has been implemented, the lead agency should develop a process with its network of community treatment partners that allows for the regular exchange of information on the availability of treatment services. Jurisdictions should strive to exchange information as close to real-time as possible so that first responders are made aware of openings in treatment programs or other services that could be used by an individual they encounter in the community. Web-based resources or community 2-1-1 telephone lines can be helpful in locating services based on an individual's location. One such example is lookupindiana.org, sponsored by the Lutheran Foundation of Indiana.

Law enforcement and first responders are by nature of their positions the first people called in a crisis or emergency. By collaborating with community stakeholders, efforts to divert individuals to treatment services can be improved. In upcoming months, COSSAP training and technical assistance providers will be developing resources on the use of case management, peer recovery support, and telehealth, all of which can play a significant role in enhancing access to treatment services. Please check future editions of the COSSAP newsletter for more information.

Endnote

[1] For more information on treatment capacity, refer to TASC's Center for Health and Justice's Treatment Capacity series (2019) http://www2.centerforhealthandjustice.org/content/project/tasc-chj-treatment-capacity-expansion-series.