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Georgia Department
of Behavioral Health
& Developmental
Disabilities

Continuum of Care

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SECTION 1 CONTINUUM OF CARE

1.1 BACKGROUND

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) serves as the Single State Agency (SSA) for Behavioral Health. Behavioral Health includes both Mental Health and Substance Use Disorders. DBHDD's Office of Addictive Diseases (OAD) and Office of Behavioral Health Prevention and Federal Grants (OBHPFG) recommend all DBHDD, and designated opioid regions develop a comprehensive Opioid Use Disorder (OUD) Continuum of Care.

Exhibit 1-1: Seven Components of the Opioid Use Disorder Continuum of Care Model is the proposed OUD Continuum of Care model that consists of the following components and should be considered the model and blueprint needed in each DBHDD and designated opioid settlement region by the Regional Advisory Councils (RACs) and the Government Participation Mechanism (GPM) henceforth called the Georgia Opioid Settlement Advisory Commission (GOSAC).

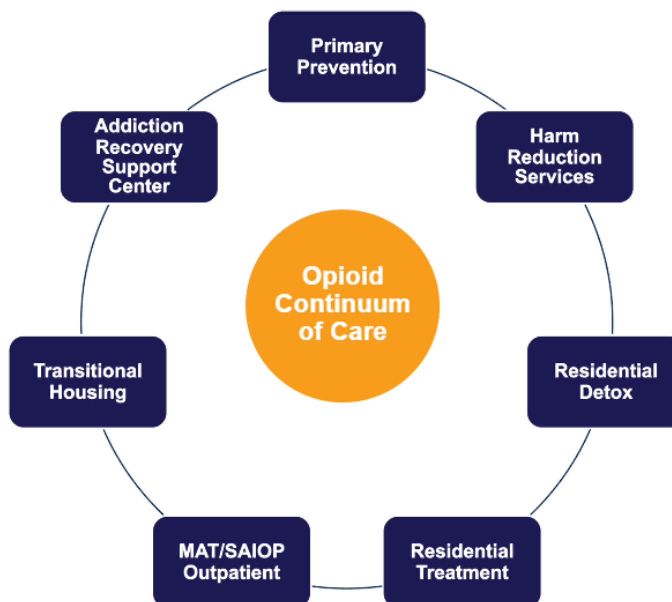

Exhibit 1-1: Seven Components of the Opioid Use Disorder Continuum of Care Model

1.2 JUSTIFICATION

The development of this continuum of care in all 11 of the DBHDD and designated opioid regions will increase the access to care for OUD, improve overall treatment outcomes and

reduce overdose deaths. All treatment services would support the use of Medication Assisted Treatment (MAT) as part of the treatment process. In addition, residential and outpatient services would consist of non-traditional hours and support educational and employment pursuits as part of the programming. Peer support services should also be used in all treatment and recovery support programs. Further descriptions of each of the seven Components of the Opioid Continuum of Care are provided on the following pages.

1. **Primary Substance Misuse Prevention Services** consist of measures aimed at the general population and susceptible populations or individuals. The purpose of primary prevention is to prevent substance use disorders, including OUD, from ever occurring using evidence-based prevention strategies. Thus, its target population is individuals across the lifespan from children to adults. Educational materials should be tailored to each group and evaluated to ensure efficacy, and performance metrics should be tracked throughout. OBHPFG institutes activities that limit risk exposure and/or increase protective factors in individuals at risk to prevent substance use from progressing in a susceptible individual to a diagnosable clinical disorder. Multi-level evidence-based/evidence-informed approaches, including universal, selective, and indicated level strategies, have proven to be best practice.

    - Universal strategies target an entire population (local community, school, and neighborhood) with messages and programs aimed at preventing or delaying the misuse of illegal and prescription drugs. Members of the population share the general risk for substance misuse, although the risk may vary among individuals.
    - Selective prevention strategies target subsets of the total population at risk for substance misuse by virtue of their membership in a particular population segment (e.g., children whose parents have/have had a substance misuse disorder, LGBTQIA+ individuals, individuals with a history of trauma, individuals impacted by health disparities, college students, older adults, athletes, etc.). Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. The selective prevention program is presented to the entire subgroup because the subgroup is at higher risk for substance misuse than the general population. An individual’s personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the identified at risk subgroup.
    - Indicated level strategies focus on populations identified as already using or engaged in other high-risk behaviors. Prevention interventions are aimed at preventing heavy or chronic use.

    The Strategic Prevention Framework is a strategic planning process used to guide communities and states in developing and implementing comprehensive substance abuse prevention activities. Prevention activities should be evidence-based and can span across a variety of different categories. DBHDD recommends considerations of

distributing prevention activities across the six categories identified by the Institute of Medicine (IOM): 1) Information Dissemination, 2) Education, 3) Alternatives, 4) Problem Identification and Referral, 5) Community-based Process, and 6) Environmental. Additional information and guidance for planning and developing primary prevention activities can be found in Appendix A.

2. **Harm Reduction Services** involves the development of programs that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs, such as opioids, without necessarily reducing drug consumption. Harm reduction emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social wellbeing; and offer low barrier options for accessing health care services, including substance use and mental health disorder treatment.[1] The Harm Reduction approach to the opioid crisis provides the opportunity to engage in community outreach and service connection to address two major health crises that currently follow the opioid epidemic, HIV and Hepatitis C (HEP C). Additional critical components of harm reduction include syringe exchange programs and access to Naloxone.

3. **Stand-alone/ Residential Detoxification** service is designed to care for individuals whose chemical dependence/withdrawal signs and symptoms are sufficiently severe enough to require 24-hour, 7 days per week medical management and supervision by appropriately trained medical and nursing staff in a permanent facility with inpatient beds. MAT induction should be considered during detox if clinically appropriate with a referral to ongoing MAT services.

4. **Addictive Diseases Residential Service** (associated with ASAM Level 3.5) provides a planned regimen of 24-hour observation, monitoring, treatment, and recovery supports utilizing a multi-disciplinary staff for individuals who require a supportive and structured environment due to OUD. This Intensive level of Residential Service maintains a basic rehabilitative focus on early recovery skills, including the negative impact of substances, tools for developing support, and relapse prevention skills. There are varying levels of care which includes step-down models, intensive, semi-independent, and independent programs. For each of these levels, there is a need for separate gender specific programs for both men and women, and programs specifically focused on transition aged youth (18-25). *This step in the continuum is critical for psychological, emotional, and environmental stabilization of individuals with OUD.*

5. **Medication Assisted Treatment / Substance Abuse Intensive Outpatient Programs Outpatient Program** (**SAIOP)** is designed for adults eighteen (18) years or older who require the use of medication to support their recovery from OUD utilizing a multi-disciplinary team to treat and support sustained recovery, focusing on early recovery skills, including the negative impact of substances, tools for developing support, and

[1] Substance Abuse and Mental Health Services Administration, Harm Reduction. Accessed online at: https://www.samhsa.gov/find-help/harm-reduction

relapse prevention skills. The duration of treatment should vary with the severity of the individual's illness and response to treatment based on the individualized treatment plan, utilizing the best/evidenced based practices for the service delivery. SAIOP is a level of care also provided in these settings on as needed basis and a setting appropriate for integration of MAT. *This service can be delivered during the day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school. Programs funded under this strategy may include Narcotic Treatment Programs (NTPs), and MAT programs that are not NTPs and do not prescribe methadone.*

6. **Transitional Housing** provides a less restrictive residential setting with reduced supervision in conjunction with off-site treatment utilizing medication to support long-term recovery from OUD as appropriate. Linkage to and use of MAT when appropriate should be considered as part of the program. As with Residential Services, there is a need for separate gender specific Transitional Housing programs for both men and women. The transitional program is designed to help individuals begin to strengthen their living skills and focus on creating financial, environmental, and social stability to increase the probability of long-term recovery beyond the artificial environment.

7. **Addiction Recovery Support Centers (ARSCs)** offer a set of non-clinical, peer-led activities that engage, educate and support individuals and families successfully to make life changes necessary to establish, maintain and enhance recovery (health and wellness) from substance use disorders. Activities are individualized, recovery-focused, and based on a relationship that supports a person's ability to promote their own recovery. Activities include social support, linkage to and coordinating among other service providers, eliminating barriers to independence and continued recovery. Most Addiction Recovery Support Centers are staffed with or led by individuals who are Certified Peer Specialists. ARSCs are vital because they assist in the support of recovery lifestyle and destigmatizing social norms.

1.3 Implementation Considerations

Various factors such as existing infrastructure, provider capacity, and OUD burden need to be considered when establishing the appropriate distribution of funding across activities for each region. Implementation of the OUD Continuum of Care should be initiated with an environmental scan/need assessment of each DBHDD and designated opioid settlement region to determine, at minimum, the following:

- Current components already in place and operational - may reduce costs.
- Gaps in the continuum of care - assessment to determine if more than the recommended number of components are needed to cover the population of the region and need for services across prevention, treatment, and recovery.
- Current providers operating in the region and ability to develop and deliver missing components.

- Consideration of private providers’ current availability/capacity is limited to meet the needs.
- Snapshots of performance metrics are currently being used to track progress by region.

1.4 Evolution and Sustainability

It is expected that the Opioid Continuum of Care in each region will evolve over time. As programs and interventions are implemented, and enhancements in each of the seven components are realized, the needs of the region will change. Sustainability of implemented efforts should be considered to enable the region to focus funding on new areas of need without impairing progress on gains achieved.

SECTION 2 PRIMARY PREVENTION GUIDANCE AND EXAMPLES

Section 2 provides additional information to support the development of primary prevention strategies and activities. Topics addressed include:

- Strategic Prevention Framework
- Key Definitions
- Institute of Medicine's Categories for Prevention Activities
- Sample Evidence-Based Programs
- Resources for Finding and Selecting Evidence-based Strategies

2.1 STRATEGIC PREVENTION FRAMEWORK

The Strategic Prevention Framework[2] is a strategic planning process used to guide communities and states in developing and implementing comprehensive substance abuse prevention activities. Cultural Competence and Sustainability are incorporated across all five steps of the model process which guides communities to:

- Assess the community - understand the substance use and related problems in the community and how to determine the resources and readiness of the community to address the identified problems.
- Build capacity of the community - community readiness and resources to address problems.
- Planning with the community – use data (from the assessment) and community stakeholders to create a comprehensive plan to address the risk and protective factors for the substance use problems in the community (select evidence-based strategies for the identified population and problem).
- Implement the evidence-based strategies appropriate for the problem and populations of the community with fidelity.
- Evaluate your implementation (performance measures) and results (outcome measures).

[2] Substance Abuse and Mental Health Services Administration, A Guide to SAHMSA's Strategic Prevention Framework: https://www.samhsa.gov/sites/default/files/samhsa-strategic-prevention-framework-guide-08292019.pdf

2.2 KEY DEFINITIONS

Below are the key definitions:

- **Mental Health Promotion** refers to interventions (e.g., programs, practices, or environmental strategies) that help people take charge of their life and improve their well-being. Promotion focuses on the general population or a particular defined population group. Its aim is to enhance people's ability to achieve developmentally appropriate tasks, acquire a positive sense of self-esteem, mastery, well-being, and social inclusion, strengthen their ability to cope with adversity.
- **Prevention** involves interventions that occur prior to the onset of a disorder and are intended to prevent or reduce risk for the disorder.[3] Substance Abuse Prevention is not just about eliminating a negative behavior, but it is about striving to optimize well-being. Prevention is divided into sub-categories of Universal Prevention, Selective Prevention, and Indicated prevention.
    - Universal Prevention interventions focus on the entire population – broadest approach not based on risks (whole populations in a school, a whole community, or workplace).
    - Selective Prevention interventions focus on individuals or a population sub-group whose risk of developing mental disorders (or substance abuse disorders) is significantly higher than average.[3] They focus on biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population. The increased risk should be based on research not assumptions and stereotypes.
    - Indicated Prevention interventions focus on high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorders.[3] They focus on immediate risk and protective factors present in the environments surrounding individuals.
- **Risk and Protective Factors** influence multiple contexts of a person's life - the individual, the family, the community (includes school or work), and the society. Since multiple contexts influence people's lives, multiple interventions are necessary to reduce substance abuse and promote emotional well-being. Prevention employs interventions that support and increase protective factors and decrease risk factors. For example, resilience is the ability to recover from or adapt to adverse events and is therefore a protective factor. Culture is also a protective factor.
- **Developmental Perspective** is critical for selection of appropriate individual level interventions. Different age groups have different risk and protective factors.

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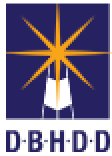
[3] National Research Council and Institute of Medicine. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities (O'Connell, ME, Boart, T, & Warner, KE, Eds.). Washington, DC: National Academies Press.

- **Shared Risk and Protective Factors -** Some risk and protective factors are the same for different problems. They tend to be correlated, have cumulative effects, and are predicative of multiple issues (data on these can be found in Monitoring the Future and the (Youth Risk Behavior Surveillance System).

2.3 Institute of Medicine's Categories For Prevention Activities

Exhibit 2-1: Institute of Medicine's Categories for Prevention Activities provides the Institute of Medicine (IOM)'s six prevention activity categories and examples of each. Evidence-based (e.g., research-verified) primary prevention strategies should be selected under each of these six categories:

Activity Category	Examples
Information Dissemination	▪ Clearinghouse/information resource center(s) ▪ Resource directories ▪ Media campaigns ▪ Brochures ▪ Radio/TV public service announcements ▪ Speaking engagements ▪ Health fairs/health promotion ▪ Information lines
Education	▪ Classroom and/or small group sessions (all ages) ▪ Parenting and family management classes ▪ Peer leader/helper programs ▪ Education programs for youth groups ▪ Children of substance abuser groups
Alternatives	▪ Drug free dances and parties ▪ Youth/adult leadership activities ▪ Community drop-in centers ▪ Community service activities
Problem Identification and Referral	▪ Employee assistance programs ▪ Student assistance programs ▪ Driving while under the influence/driving while intoxicated education programs
Community-Based Process	▪ Community and volunteer training, e.g., neighborhood action training, training of key people in the system, staff/officials training ▪ Systematic planning ▪ Multi-agency coordination and collaboration ▪ Accessing services and funding ▪ Community team building



Activity Category	Examples
Environmental	▪ Promoting the establishment and review of alcohol tobacco and drug use policies in schools ▪ Technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco, and other drug use ▪ Modifying alcohol and tobacco advertising practices ▪ Product pricing strategies

Exhibit 2-1: Institute of Medicine's Categories for Prevention Activities

2.4 Samples Of Evidence Based Programs

Evidence-based programs often focus on individual-level or environmental-level strategies.

Individual Level Strategies

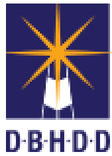
- Focus on behavior and behavior change
- Focus on the relationship between the individual and alcohol/drug related problem
- Short-term focus on program development
- Individual not involved in decision-making
- Individual as audience

Environmental Level Strategies

- Focus on policy and policy change
- Focus on the social, political, and economic context of alcohol/drug-related problems
- Long-term focus on policy development
- People gain power by acting collectively
- Individual as advocate

Exhibit 2-2: Evidence Based Program Examples provides a listing of some example evidence-based programs, outlining the program name, goal(s), components, and expected outcomes.

Program Name & Information	Goal	Program Components	Program Outcomes
Individual-Level (Universal Prevention) *Good Behavior Game*	▪ Reduce suicide ideation through the promotion of shared values and social integration ▪ Reduce behavioral infractions	Students in first and second grades learned pro-social behavioral management strategies and team-based learning strategies.	Participants reported lower rates of suicide ideation & suicidal behavior later in life, as compared with control.
Individual-Level (Targeted Prevention for High-Risk People) *Proactive Policing*	▪ Provide information about effect of underage drinking ▪ Improved communication ▪ Resistance skills	Cities increased monitoring of gun activity through proactive engagement and enforcement.	Increased patrols aimed at illegal gun carrying reduced gun violence in high-crime areas.



Program Name & Information	Goal	Program Components	Program Outcomes
Community-Level (Universal Prevention) *Youth Aware Mental Health*	▪ Mental health promotion that reduces suicidal behavior	▪ Participants role play, reflect on, and discuss topics important to youth. ▪ Trained adults facilitate discussions with youth through 5 1-hour sessions.	▪ Reduced new cases of suicide attempts and suicide ideation by 50%. ▪ New cases of depression were reduced by almost 30%.
Community-Level (Universal Prevention) *Cure Violence*	▪ Provide trained conflict mediators to reduce conflict and mediate between groups ▪ Provide outreach so that community members can access social services	▪ Violence interrupters monitor ongoing violence to “talk people down” instead of retaliation ▪ Outreach workers connect people to social services (i.e., employment, housing, recreation)	▪ In Chicago, programs are seen as an important way to resolve conflict. ▪ In Baltimore, programs reduced non-fatal shootings and fatal homicides. ▪ Results rate this approach as “promising” (i.e., not yet “effective”)
Community-Level (Targeted Prevention) *SAFETY Program*	Cognitive behavioral therapy (CBT) that aims to reduce suicidal behavior, youth & parent depression, and improves youth adjustment	12-week plan that involves enhancing support (i.e., family, peers, community) and learning/ practicing social skills.	Youths in SAFETY program showed improvements in depression, hopelessness, and suicidal ideation.
Social-Structural Level (Universal Prevention) *Alcohol Policies and Firearm Safety*	▪ Reduce negative consequences of alcohol use ▪ Reduce the suicide rates through gun safety	▪ Alcohol policies (i.e., taxes and prices; limiting hours and locations) are related to preponderance of suicide. ▪ Locking guns in safe containers.	▪ Improving pro-social alcohol policies (i.e., imposing higher costs on alcohol) reduces suicide and violence. ▪ Safe storage of guns leads to a reduction in teen suicide.

Exhibit 2-2: Evidence Based Program Examples

2.5 Resources for Finding and Selecting Evidence Based Strategies

Below is a list of resources for finding and selecting evidence-based strategies:

- Identifying and Selecting Evidence-Based Interventions
- SAMHSA Focus On Prevention, Strategies and Programs to Prevent Substance Use
- CAPT Decision-Support Tools, Preventing Prescription Drug Misuse: Programs and Strategies
- CAPT Decision Support Tools – Strategies to Prevent Binge or Heavy Episodic Drinking

- Selecting Best-fit Programs and Practices
- https://oasas.ny.gov/providers/evidence-based-prevention-programs
- Compendium of Model and Promising Strategies 2013 – Underage, Heavy and Binge Drinking
- Healthy People 2020 Evidence-Based Resources https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources
- Identifying Evidence-Based Programs National Institute of Health https://prevention.nih.gov/resources-for-researchers/dissemination-and-implementation-resources/evidence-based-programs-practices#topic-1