SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

DECEMBER 2023

ADVISORY: LOW BARRIER MODELS OF CARE FOR SUBSTANCE USE DISORDERS

Introduction

Despite robust evidence demonstrating the effectiveness of medications and psychosocial treatment interventions for substance use disorders (SUDs), less than 10 percent of people who need treatment have sustained access to care. In 2021, only 22.1 percent of people with a past year opioid use disorder (OUD) reported receiving medications for the treatment of their opioid misuse, and only 6.3 percent of people with a past year illicit drug or alcohol use disorder reported receiving any substance use treatment.[1] SUDs continue to pose a significant public health challenge. Most people who could benefit from treatment do not receive it due to systemic barriers and access issues which are even greater for historically underserved communities.

Low barrier care is a model for treatment that seeks to minimize the demands placed on clients and makes services readily available and easily accessible. It also promotes a non-judgmental, welcoming, and accepting environment. In this way, low barrier models of care meet people where they are, providing culturally responsive and trauma informed care that is tailored to the unique circumstances and challenges that each person faces.[2,3] This facilitates engagement in treatment: one recent study of a low barrier bridge clinic serving individuals with opioid, alcohol, stimulant, sedative/hypnotic, and cannabis use disorders, found that 70 percent of clients were engaged in treatment, which is higher than national averages.[4] Another study of low barrier buprenorphine offered at a syringe services program revealed a nearly three-fold increase in buprenorphine use (from 33 to 96 percent) and substantial declines in the use of other opioids (from 90 to 41 percent) between clients' first and sixth visits.[5] Other research reveals that low-barrier care is cost-effective, reducing the need for emergency department visits and hospitalizations.[6]

Key Messages

- Low barrier care reduces requirements and restrictions that may limit access to care and increases access to treatment for individuals with substance use disorders. This approach meets individuals where they are and helps provide culturally sensitive care tailored to the unique circumstances and challenges that each person faces.
- Research demonstrates the potential effectiveness of low barrier care in improving treatment engagement and outcomes for individuals with substance use disorders.[4] Low barrier care can reduce the use of harmful substances and lower the need for emergency department visits and hospitalizations.
- Some approaches to substance use disorder treatment may be perceived by people who use drugs as punitive, leading to stigmatization and limited treatment engagement. Low barrier care provides a non-judgmental, welcoming, and accepting environment that encourages individuals to seek help without fear of stigma or discrimination.
- Policymakers and stakeholders must work to identify and address any inhibitors to low barrier care, including funding and reimbursement, workforce development, and regulatory policies.
- Low barrier care can increase access to treatment and improve recovery-based outcomes for individuals and communities affected by substance use disorders.[6]

This Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory outlines the principles and components of low barrier care and how low barrier care may be leveraged to overcome substantial gaps in access, while also engaging individuals in treatment. Low barrier care for SUDs is a critical way to address the overdose epidemic and other substance use challenges. By removing barriers to care and providing evidence-based services in a non-judgmental, welcoming, and accepting environment, low barrier models of care can help to improve recovery-based outcomes for individuals and communities affected by substance use and use disorders.[2]

Principles and Components of Low Barrier Models of Care

Low barrier models of care promote engagement and retention by placing the patient at the center of planning and decision making. Accordingly, low barrier models include flexible scheduling and walk-in services, a non-punitive approach to ongoing substance use, decreased stigma about SUD compared to traditional care settings, and incorporation of patient goals and choice into medication decisions. The following principles and components of low barrier care highlight a patient-centered approach to care that meets the person where they are and engages them in treatment in a compassionate and person-centered manner.

Principles

1) **Person-centered care**: Treatment works best when the focus is on how to empower each client to achieve their goals. This requires being present to the individual, asking about, listening to, and respecting clients' experiences, wishes, and autonomy, as well as providing individualized care to meet their needs. Cultivating a culture of person-centered empowerment within organizations and systems is especially needed given the pervasive stigma against people with SUDs. In the context of low barrier care for SUDs, it is crucial to support a client's preferences for short-term versus long-term medication use (e.g., withdrawal management) as part of a patient-centered approach to treatment. This includes providing psychosocial education so that individuals understand the risks and benefits of their decisions. Respecting individual autonomy and through a shared decision-making and informed consent process can enhance treatment adherence, promote a sense of autonomy, and improve overall outcomes. Long-term medication use may offer stability and continuous support for clients, whereas short-term use can be instrumental in managing withdrawal symptoms and initiating the recovery process. By ensuring effective informed consent via shared decision-making and tailoring treatment plans to align with clients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to a more successful and sustainable recovery.[13]
2) **Overdose prevention and meeting the person where they are:** Overdose prevention and infectious disease prevention services are practical and transformative approaches that incorporate public health strategies – including prevention, risk reduction, and health promotion- to people who use drugs, so that they might live healthy and purpose-filled lives. What that looks like can vary for each client. For example, abstinence from all substances may not be a feasible or desired goal for every client at a given point in time. Other behavior changes – including reductions in substance use and engaging in less risky substance use practices – can meaningfully improve health outcomes and can be appropriate treatment goals. Similarly, recovery is determined by the person. It is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. In a low barrier setting, services and interventions are provided in a non-judgmental, welcoming, and accepting environment, which is designed to encourage individuals to seek help without fear of stigma or discrimination.[7] Low barrier care recognizes that recovery is a journey that is unique to

each individual, and therefore, emphasizes the need to provide interventions that are tailored to the unique needs and circumstances of each person.[8]

3) **Flexibility in service provision**: Low barrier models of care prioritize patient-centered care and adapt to the individual's specific needs, preferences, and circumstances by offering walk-in services, providing multiple levels of care within a single program, and using evidence-based practices to support a variety of recovery goals.[9,10]

4) **Provision of comprehensive services**: Low barrier care models often incorporate a whole health approach that encompass a range of medical, behavioral, and social services to address the multifaceted needs of individuals with SUDs, including access to medications for opioid use disorder (MOUD) and medications for alcohol use disorder (AUD), counseling, case management, peer support, mental health care, education, housing support, mental health screening and referral or co-occurring enhanced treatment, and vocational services.[9] The provision of these services may be performed onsite, or through referrals.

5) **Culturally responsive and inclusive care**: The burden of SUDs has been disproportionately experienced by people from racially and ethnically marginalized communities. Addressing these disparities requires proactive and community-involved efforts to improve access to care for communities that have been underserved, including mitigation of the upstream factors that reinforce inequities in health status, healthcare access, healthcare quality, and health outcomes. Low barrier care also emphasizes diversity, striving to provide care sensitive to the unique needs and experiences of each individual, including those belonging to marginalized populations, such as people of color, rural communities, lesbian, gay, bisexual, transgender, questioning, intersex and asexual (LGBTQIA+) individuals, people with disabilities, and those experiencing homelessness.[11,12]

6) **Recognize the impact of trauma**: Many individuals with an SUD have experienced trauma at some point in their lives. Trauma-informed care can improve patient engagement, treatment adherence, and health outcomes as it recognizes the long-lasting, negative impacts of trauma. Key principles of a trauma-informed approach include attention to (1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment, voice, and choice, and (6) cultural, historical, and gender issues.[13]

Components of Low Barrier Models of Care

In low barrier models of care, providers accommodate clients' preferences to the maximum extent possible while also working collaboratively with clients to determine recovery goals, recognizing that recovery is unique to the person. Key elements of low barrier models are availability, flexibility, responsiveness, a collaborative approach to the needs and interests of the individual, as well as promoting a culture of learning and evaluation.

Available and Accessible

Embedding SUD treatment, related services and supports across the healthcare system is critical to improving treatment engagement. Relatedly, socioeconomic factors can make it difficult for some clients to access treatment (e.g., unreliable transportation, employment, childcare responsibilities, prior authorizations). These are key considerations to increasing access to treatment for the entire population with SUDs and can be actualized through the use of telehealth technology, integrated care platforms and mobile medical units.

This model would ensure that:

- Treatment is available outside of specialty SUD settings, including in emergency departments, primary care, specialty health care (e.g., obstetrics/gynecology), syringe services programs, crisis stabilization facilities, and mobile units.[14,15]
- Other clinical (e.g., primary care, mental health care) and non-clinical services (e.g., syringe access, peer support services, case management) are incorporated into specialty SUD treatment settings.[16]
- Individuals can receive services on the same day without an appointment.[6,14]
- Clinics have extended hours of operation.[16]
- Telehealth and in-person services are available.[17] This is especially important for individuals in remote or underserved areas, eliminating transportation barriers.

EXAMPLE: Meharry Addiction Clinic

Meharry Addiction Clinic (MAC), part of the Meharry Medical College and located in North Nashville, TN, emphasizes the importance of building strong relationships between staff and clients, and community and providing person-centered care. MAC does not discharge clients for ongoing substance use and they provide overdose prevention services – naloxone, and fentanyl test strips– to all clients with OUD. To reduce barriers to their services, MAC is implementing a mobile addiction clinic and increasing their outreach to emergency departments, faith-based organizations, and Black community members.

Flexible

Low-barrier models adapt to the individual's specific needs, preferences, and circumstances, offering walk-in services, providing multiple levels of care within a single program, and using evidence-based practices to support a variety of recovery goals. Rigid requirements and expectations imposed on clients can deter them from seeking, initiating, or sustaining treatment.

- Treatment engagement conditions or preconditions should not be placed on the patient. This includes requirements that individuals receive multiple services simultaneously; demonstrate complete adherence with scheduled intake appointments; complete additional testing prior to starting medication or receiving dose increases; receive treatment for co-occurring conditions (e.g., mental disorders); or provide consent to co-occurring treatment providers before SUD treatment initiation are required conditions of treatment.[18,19]
- Medication is provided at the first visit if the patient chooses. Additionally, the provision of medication is not contingent on a positive urinary drug screen or active withdrawal.[14,20]
- Home initiation of medications is offered.[14,17]
- Various formulations of medications are offered.[14]
- Medication dosage and duration of therapy are individualized.[16]
- Medication is rapidly re-initiated if person chooses when there is a short-term treatment disruption.[14]
- If desired by the individual, counseling can teach new ways to make healthy choices and handle stress. While counseling should be offered to patients, the provision of medication should not be contingent upon participation or engagement in a set counseling schedule.
- The use of toxicology results to prioritize client safety, rather than punishment, helps to establish trust, promote transparency, and facilitate a more effective therapeutic alliance,

ultimately enhancing treatment outcomes and mitigating potential adverse outcomes. In other words, the results of tests are not used to restrict services.

Responsive

Recovery is a highly personal process that occurs via many pathways. Each person with a SUD will have a different approach to cultivating and sustaining recovery. People with SUDs benefit from comprehensive services to support them on their path to recovery, and low barrier care does not preclude offering a full range of services to the individual in a person-centered manner. Indeed, practitioners in low barrier settings play a vital role in providing a full continuum of support, which includes community-based services, family support, and peer support, all of which ensure those with SUDs have access to whole person care.[16]

- Visit frequency is based on clinical stability, not an organization-wide schedule (except for interventions that employ specific visit schedules by design, such as contingency management).[14]
- Ongoing substance use, whether by self-report or demonstrated through specimen testing, does not automatically lead to treatment discontinuation or a reduction in medication dose.[14,16]
- Being prescribed medications for mental health conditions does not automatically preclude MOUD, nor should programs mandate those receiving MOUD provide consent to release information to their mental health prescriber as a contingency of continued SUD treatment.
- Providers support clients in determining their recovery goals based on what feels right for them, including medication choice.[16]
- Reducing substance use and harm mitigation are considered acceptable goals.[14,16]
- Peer services or nonclinical professionals with lived experience in recovery from SUD are available to support people on their recovery journeys by providing education about how to care for and strengthen recovery, help advocate for people in recovery, share resources, and provide mentorship.
- Providers should work with patients and their care team to determine what services are needed to support their growth in the four domains of recovery (health, home, purpose, and community).[21]
- Families should be involved based on the wishes of the individual.
- Clinic staff use outreach and follow-ups to encourage treatment adherence and attendance.[22]

Collaborative

To address the complex needs of individuals with SUD, low barrier care programs often partner with other community organizations, including:

- Primary care providers;[23]
- Mental health services;[24]
- Housing agencies;[25]
- Social services;
- Transportation services;
- Offices of employment; and
- Peer support networks.[26]

Engaged in learning and quality improvement.

Adequate training and education of healthcare providers and staff members in low barrier care principles, evidence-based treatment practices, signs and symptoms of co-occurring disorders, recovery-oriented care, and overdose prevention strategies are crucial to delivering effective care for people with SUDs.[20] It is also important to foster program evaluation and feedback mechanisms, as these underlie quality improvement activities.[27] Implementing these strategies can involve:

- Enhancing knowledge about the latest evidence-based interventions for SUDs, including medications, counseling, and recovery support services.[20,28]
- Providing information on the principles and benefits of approaches such as overdose prevention, and syringe services programs.[29]
- Offering cultural competence training to better understand and address the diverse needs of clients from various cultural, racial, and ethnic backgrounds, as well as the LGBTQIA+ community.[30]
- Encouraging continuing education and professional development opportunities for staff and providers, including conferences, webinars, and workshops related to SUDs and low barrier care.
- Collecting and analyzing data on treatment outcomes, client satisfaction, and accessibility of services, using standardized measures and tools.[31]
- Incorporating feedback from clients, staff, and community partners to identify strengths and weaknesses of the low barrier care model and to inform service improvements.[32]
- Conducting regular reviews of clinical practices and policies to ensure alignment with the latest research evidence and best practices in the field.[33]
- Establishing a culture of continuous quality improvement, where staff and providers are encouraged to learn from successes and challenges, and to adapt and innovate in their approaches to care.[34]

These components facilitate a comprehensive, integrated approach to care, while also enhancing the effectiveness of treatment and support services. In this way, comprehensive implementation of low barrier care requires systemic policy and practice transformation at every level.

Exhibit 1: A Comparison of Low-Barrier and High-Barrier Care

	Low-Barrier Care	High-Barrier Care
Requirements and Approach[35,36,37,38,39,40]	No service engagement conditions or preconditions.	Requirements for current or previous engagement with specific services.
	Visit frequency based on clinical stability.	Visit frequency based on a rigid, pre-determined schedule.
	Ongoing substance use does not automatically result in treatment discontinuation.	Treatment discontinuation due to ongoing substance use.
	Client's individual recovery goals prioritized.	Treatment goals imposed.
	Reduction in substance use and engaging in less risky substance use as acceptable goals.	Abstinence as the primary goal for all clients, all the time.
	Medication at first visit.	Two or more visits before medication.
	Home initiation permitted.	Clinic initiation required.
	Various medication formulations offered.	Limited medication formulation options.
	Individualized medication dosage.	Uniform maximum dosage.
	Rapid re-initiation of medication after short-term disruption.	Induction required to restart medication.
Availability[41,42,43,44,45]	Treatment available in non-specialty SUD settings.	Treatment only available at specialty SUD programs.
	Other clinical and non-clinical services incorporated into SUD treatment settings.	Non-integrated or limited-service offerings.
	Same-day treatment availability, no appointment required.	One or more day wait to initiate treatment, appointment required.
	Extended hours of operation.	Traditional hours of operation.
	Telehealth and in-person services available.	Services only available in-person.

This table was adapted from a table developed by Jakubowski and Fox.[35] Shading indicates that the component applies only to medication.

A Brief Implementation Example

Implementing low barrier models of care into primary care settings, including Federally Qualified Health Centers (FQHCs), involves a comprehensive approach that addresses the various components of patient-centered care, including availability, flexibility, responsiveness, collaboration, and a culture of learning. Below are some important examples of required elements in promoting low barrier models of care in primary care settings:

- **Establish a multidisciplinary care team**: Assemble a team of healthcare professionals, including physicians, nurses, counselors, marriage and family therapists, social workers,

and peer support specialists, to provide comprehensive care to patients with substance use disorders.[46]

- **Integrate SUD screening and assessment**: Incorporate routine SUD screening and assessment into primary care settings using validated tools, such as the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST).[47]
- **Involve people with lived experience**: Meaningfully engage people in recovery and family members in the planning, delivery, and evaluation of services. Include people in recovery in leadership and board roles.
- **Train primary care providers**: Provide training and education for primary care providers on the fundamentals of addiction medicine, evidence-based treatment options, and the use of medications for SUD, such as buprenorphine.[48]
- **Develop collaborative care protocols**: Establish protocols that outline communication and coordination processes among primary care providers, behavioral health specialists, and other community-based service providers.[49]
- **Offer flexible treatment options**: Provide various treatment options, including medications, counseling, and overdose prevention services, which cater to the individual needs and preferences of patients with SUDs.[50]
- **Eliminate service engagement preconditions**: Ensure that treatment initiation is not contingent on factors such as strict adherence to scheduled appointments or the requirement to receive treatment for co-occurring conditions before initiating SUD treatment.[50]
- **Address stigma**: Provide ongoing education and training to staff members to challenge misconceptions about addiction and promote empathy and understanding towards individuals with SUDs. This can help reduce stigma and create a welcoming, non-judgmental environment.[51]
- **Establish referral networks**: Develop strong partnerships with local mental health, social services, and housing organizations to facilitate access to additional support and resources for patients, thereby fostering a comprehensive continuum of care.[48]
- **Evaluate and continuously improve**: Regularly assess the effectiveness of the low barrier care model through the collection and analysis of patient outcomes, satisfaction, and engagement data. Use the insights gained to refine and enhance service delivery.[49]

Through careful implementation of these steps, primary care settings can successfully implement low barrier models of care, fostering an accessible and patient-centered environment for individuals with SUDs.

Providing Comprehensive Patient-Centered Care: Treating The "Whole Person" Through Low Barrier Care

People with SUDs benefit from comprehensive services to support them on their path to recovery, and low barrier care does not preclude offering a full range of services to the individual in a person-centered manner. Indeed, practitioners in low barrier settings play a vital role in ensuring that those with SUDs are offered "whole person" care. This can include addressing concerns that the individual may have about their physical and mental health, financial, or housing needs. Practitioners should consider the following issues when caring for individuals.

- **Treatment decisions are person-centered**. In the context of low barrier care for substance use disorders, it is crucial to support a client's preferences for long-term versus short-term medication use (e.g., withdrawal management) as part of a patient-centered approach to treatment. By ensuring effective informed consent and tailoring treatment plans to align with clients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to more successful and sustainable recovery trajectories. For more information on treating opioid use disorders, see SAMHSA's TIP 63 - Medications for Opioid Use Disorder (https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002). Information on treating stimulant use disorders can be found in TIP 33, available at https://store.samhsa.gov/product/treatment-for-stimulant-use-disorders/PEP21-02-01-004. Information on treating alcohol use disorder is available at: https://store.samhsa.gov/product/prescribing-pharmacotherapies-patients-with-alcohol-use-disorder/pep20-02-02-015. Information on treating co-occurring disorders can be found in TIP 42, available at: https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004?referer=from_search_result.

- **The use of telehealth expands access**. Audio-only and/or audio-visual telehealth technologies can be helpful in reaching individuals in remote settings or connecting to those people who are reluctant to receive care in physical settings. A growing amount of research has demonstrated the effectiveness of using telehealth in treating OUD with medications. More information about telehealth and treating substance use disorders can be found in SAMHSA's evidence-based guide on 'Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders', available at: https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders.

- **Biological specimen testing is not punitive**. In low barrier care for substance use disorders, the use of biological specimen test results, obtained after appropriate patient education and consent, holds significant value for informing clinical decision-making with respect to client safety, as opposed to punitive applications. By providing objective data on a client's substance use patterns, these tests can guide healthcare providers in adjusting treatment strategies, ensuring appropriate interventions, and monitoring client progress, all while considering the individual's unique needs and risk factors. Utilizing test results to prioritize client safety helps to establish trust, promote transparency, and facilitate a more effective therapeutic alliance, ultimately enhancing treatment outcomes and mitigating potential adverse consequences associated with substance use disorders. Further information about biological specimen testing can be found at: https://store.samhsa.gov/product/TAP-32-Clinical-Drug-Testing-Primary-Care/SMA12-4668.

- **Counseling can help people enhance their coping skills**. If desired by the individual, counseling can teach new ways to make healthy choices and handle stress. The provision of medications for treatment should not be contingent on participation in counseling, but it should be offered as indicated. This is because the combination of counseling and medications has been shown to be of significant benefit to the individual. Practitioners can help patients locate services using the Treatment Services Locator (https://findtreatment.gov).

- **Peer workers**, or non-clinical professionals with lived experience in behavior change and recovery from SUD, can support people on their recovery journeys. Peer workers support people in or seeking recovery from SUDs by providing education about triggers

that can lead to recurrence, advocating for people in recovery, sharing resources, teaching skill-building, and mentoring. For more information about peer workers, see https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

- **People seeking care may also have other health issues**. Practitioners should work with clients to ensure access to additional health services as needed. Indeed, those with SUDs may have physical or mental health conditions that they wish to be addressed. For more information about referral centers in your local area, see https://findtreatment.gov/.
- **Additional Supports**. Additional supports such as family therapy and vocational counseling should be offered to the patient with the understanding that such services may not be accepted immediately, and that engagement might be sporadic. For more information on employment and recovery, see https://store.samhsa.gov/product/Substance-Use-Disorders-Recovery-with-a-Focus-on-Employment/PEP21-PL-Guide-6. Additional information on family therapy can be found at https://store.samhsa.gov/product/importance-family-therapy-substance-use-disorder-treatment/pep20-02-02-016.
- **Caring for people with SUDs is empowering** for the provider and patient. Expanding skills and knowledge through learning about medications to treat SUDs, prescribing buprenorphine to patients with OUD, and engaging with other resources provides a practical way to help a growing number of individuals. In December 2022, the requirement to obtain a special waiver to prescribe buprenorphine was lifted. Now, where state law allows, any practitioner with a valid state license and DEA registration to prescribe Schedule III medications may prescribe buprenorphine. This expands opportunities to provide care and the ability to provide low barrier treatment to those with OUD across different settings. For more information on removal of the Data-Waiver, see https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement.

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SAMHSA ADVISORY

Acknowledgments: This Advisory was produced for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS283201700074I/75S20322F42003 with SAMHSA, U.S. Department of Health and Human Services (HHS). Dr. Robert Baillieu served as Product Champion, and Suzanne Wise served as the Contracting Officer's Representative (COR).

Recommended Citation: Substance Abuse and Mental Health Services Administration. Low Barrier Models of Care for Substance Use Disorders. *Advisory*. Publication No. PEP23-02-00-005. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023.

Publication No. PEP23-02-00-005
Released 2023