Kentucky Substance Use Disorder (SUD) Program Performance Indicators and Client Barriers to SUD Program Engagement: A Multi-Perspective Study

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Brief bullet points are provided below based on a report derived from four separate studies documenting barriers, particularly barriers that could be addressed with policy changes or targeted funding, to client engagement in Kentucky SUD programs. The four projects are briefly described. The integrated conclusions are organized into five main questions.

Background

Nationally, substance use has increased over time despite significant efforts targeting reduction of substance use. Similar to national rates, substance use disorders (SUD) have increased over time in Kentucky with significant consequences.

SUD program exposure can and does make a significant difference in helping people with recovery (Jones, Noonan, & Compton, 2020). Staying in a SUD program for at least three months is associated with better recovery outcomes (Nsimba, 2007). However, research estimates that about 80% of individuals drop out of SUD programs between the first call and 30 days completion of the program (Loveland & Driscoll, 2014).

Addressing the full scope and nature of barriers and facilitators to service access and utilization is crucial. However, most studies focus only on individual-level barriers rather than systemic or program level barriers (Brorson, Arnevik, Rand-Hendricksen, & Duckert, 2013).

Goals

The overarching goal of these studies was to examine performance indicators for SUD treatment and identify barriers, particularly plausibly addressable barriers, to SUD program engagement in Kentucky. There are three main objectives this study examined:

1. Identify key SUD performance indicators recommended by the literature and compare client-level performance indicators by specific program/region and statewide across three Kentucky SUD program outcome datasets (Performance Indicators Project; Project 1).

2. Describe SUD services program level performance indicators (including types of evidence-based practices used as well as barriers to using evidence-based practices), and barriers SUD program staff have in serving SUD clients (Provider Survey Project; Project 2).

3. Explore unmet treatment needs as well as personal, program, and systemic barriers to SUD treatment in Kentucky among adults who need, but who do not engage, with SUD treatment (have not entered a program or who have dropped out of a program in the past year) (Consumer Survey Project; Project 3 and Secret Shopper Project; Project 4)

Four Projects (January 1, 2023- June 30, 2023)

PROJECT 1: PERFORMANCE INDICATORS PROJECT

Method: (1) literature review on SUD program indicators; (2) client-level outcome performance indicators from KTOS, RCOS, and CJKTOS; (3) longitudinal trends in client outcomes; and (4) client overlap across datasets.

Report: *State of performance indicators in SUD treatment: How does Kentucky measure up?*

Check Out: Profiles for performance indicators overall for Recovery Kentucky, CMHCs, and DOC Prison SAP and individual profiles of performance indicators for each CMHC region (Appendices C and D of the report).

PROJECT 2: PROVIDER SURVEY PROJECT

Method: Data from surveys with providers (n = 833) about their perceptions of performance indicators and client barriers to SUD program engagement in CMHCs (n = 615), Recovery Kentucky (n = 130), prenatal programs (n = 53), and DOC-related programs (n = 35). Results provided by program and overall and are divided into five main sections including: (1) client barriers to SUD program engagement; (2) challenges to working with SUD clients; (3) organizational challenges and rewards experienced by program staff; (4) key program performance indicators; and (5) services provided for clients.

Report: *What Do Providers Say about Client Barriers to SUD Program Engagement?*

Check Out: Staff perceptions of barriers for SUD clients in their own words.

PROJECT 3: CONSUMER SURVEY PROJECT

Method: Data from interviews with 62 diverse consumers who thought about but did not enter treatment in the past year (41.9%) and/or who dropped out of treatment in the past year (66.1%) about barriers to SUD program engagement. Results are divided into four main sections including: (1) substance use history; (2) SUD treatment utilization and entry barriers; (3) SUD treatment retention and barriers; and (4) SUD treatment-related needs.

Report: *Understanding Barriers to SUD Treatment in Kentucky from the Consumer Perspective.*

Check Out: Consumer thoughts about SUD barriers in their own words.

PROJECT 4: SECRET SHOPPER PROJECT

Method: Data from secret shoppers' 71 attempts to make a first appointment (3 attempts during business hours and 2 attempts after business hours) with CMHCs (n = 14 regions) and prenatal programs (n = 4 programs) as well as to get referrals for SUD programs from referral lines (n = 2). Individual reports for CMHC regions, prenatal programs, and referral lines are presented.

Report: *Hello, Is Anyone There? Results of A Secret Shopper Project to Make a First Appointment for SUD Treatment in Kentucky.*

Check Out: Individual secret shopper results for each CMHC region, prenatal program and referral line included in the study (Appendix A, B, and C)

OVERALL PROJECT CONCLUSIONS AND RECOMMENDATIONS

Method: (1) summary of four projects and (2) integrated conclusions and recommendations.

Report: *Kentucky Substance Use Disorder (SUD) Program Performance Indicators and Client Barriers to SUD Program Engagement: A Multi-Perspective Study.*

Check Out: Integrated conclusions and recommendations, examples of CMHC, Recovery Kentucky, and DOC SAP program indicator profiles and overall secret shopper results for CMHCs and prenatal programs.

Integrated Conclusions

(1) Why does the first phone call for an appointment for a SUD program matter?

Given the estimate that 45% of individuals do not show up for their first SUD appointment, the first phone call may be one of the most important steps in engaging clients in SUD programs.

a. Consumers overcome several key personal barriers when making that first phone call for SUD programs including embarrassment, shame, fear, and anxiety. Standardizing the script for that first phone call and ensuring a warm and friendly tone is crucial, even if those consumers do not show up for that appointment. If consumers perceive negative, blaming and stigmatizing interactions even during that first call, they may be less motivated to enter the program. The hope is that they will re-engage in SUD programs, and re-engage quicker, if that first attempt at an appointment is positive.

b. Having staff ask about scheduling preferences and providing information such as helping consumers know where to find the program, what to bring, and what to expect may be helpful in engaging consumers in SUD programs.

c. Additionally, the first phone call could be used to educate consumers about SUD program approaches so the consumers are clearer about their expectations for what will happen and have more of a choice regarding what might be the best fit for them.

d. The first phone call could be used to conduct a very quick risk assessment, particularly for vulnerable individuals such as those with recent incarceration, overdose risk, suicidality risk, personal safety risk, and pregnancy. After the risk assessment, it may be helpful to provide some brief information, if consumers are interested, regarding overdose and Narcan, detox, AA/NA, prenatal services, and/or local domestic violence services as well as national hotlines may be important regardless of how long consumers have to wait for the appointment.

(2) How can SUD programs make the recovery journey more successful for clients?

Three main themes emerged about what may increase the likelihood of recovery success including:

Facilitating community and support for recovery can help clients with their resource needs, care for children, and with their sense of belonging. SUD programs can facilitate supportive relationships with clients' family and other people, if clients wish, through education to family members as well as providing support for client support members themselves. In addition, one of the most valuable assets in SUD programs are peer support workers. Program staff also talked about the significant benefit of having peer support workers as part of the program.

Allowing ***opportunities for client choices*** may help increase personal motivation. Consumers in the SUD program discussed feeling that the rules and regulations made them feel overwhelmed and constrained.

Having flexibility, or even small opportunities for choice, to meet client needs (e.g., harm reduction strategies, having input and support to taper off of MOUD/MAT, flexibility of program hours, smoking cessation, program approach [i.e., MOUD/MAT, abstinence based]) can help clients feel more in control of their own well-being. Also, having flexibility with regard to scheduling throughout the program so that clients can navigate their recovery and their personal life (and so their personal resources, such as their employment and housing, are not threatened) may be important.

One of the most valuable assets in SUD programs is the staff. Identifying, addressing, and monitoring ***staff barriers*** is crucial to maximizing staff tools, support, and time to support their clients.

(3) Who is at risk of having unmet SUD treatment needs?

Across several key questions from the provider and consumer surveys the following populations were identified as having the most difficulty with SUD programs or providers thought they could be better served by their SUD program.

(a) individuals with co-occurring mental health problems; (b) youth including adolescents (11-17) and young adults (18-24 years old); (c) women and particularly pregnant and post-partum women; (d) individuals who are homeless; (e) marginalized individuals (e.g., racial/ethnic minorities, LGBTQ+, non-English speaking); (f) individuals with limited personal resources; (g) individuals with co-occurring vulnerabilities other than mental health (e.g., physical, developmental, or learning disabilities, chronic pain); (h) seniors/older adults (55+), and (i) veterans and persons on active duty in the military and their families.

It may be important to track demographic information associated with who is, and who is not, being served. Tracking program engagement among vulnerable groups of individuals may need deliberate attention and sharing the information with program staff so that progress and setbacks can be monitored by the organization.

Increased difficulty engaging in SUD programs is often related to adaptability barriers. Adaptability barriers exist because SUD programs have not made the necessary changes to address the unique needs or vulnerabilities of clients.

(4) What is the state of measuring SUD program quality in Kentucky and why does it matter?

Many states' performance indicator efforts focus on access and process factors of SUD treatment, with less attention to client outcomes, because of the cost, lack of human resources, and difficulty of carrying out systematic evaluations (Harris et al., 2009). Thus, Kentucky's multi-year client-level outcome evaluations are a valuable resource for understanding and informing publicly funded SUD treatment in the state. The client-level outcomes and clients' perceptions of care collected in the three outcome evaluations (KTOS, RCOS, CJKTOS) map well onto the outcomes considered important in the performance measurement literature as outlined in the Performance Indicators Project Report: return to substance use, symptoms, functioning, recovery supports, well-being, and client perceptions of care. These Kentucky studies also provide feedback regarding specific aspects of the SUD program that worked or did not work well for clients. The findings from the outcome evaluations are shared with the provider organizations and DBHDID, as well as posted on UKCDAR's website, which can be accessed by the public.

The majority of providers indicated their organizations are tracking a lot of information about program performance; however, the information is not transparent or shared widely in a way that staff or consumers can use. Transparency in performance is crucial to educating consumers about SUD programs as well as others who are investing in these programs. The performance indicators must be feasible, reliably and systematically collected, and collected in a way that can be reported without burdensome digging through electronic health records. Key stakeholders in collaboration (including consumers, providers, and DBHDID) are in the best position to select program performance indicators based on their priorities.

Based on the research literature and the findings of the four projects, in addition to the performance indicators already collected, some recommended performance indicators for SUD programs in Kentucky are:

a. structure indicators (such as information about staffing, number of peer support specialists, process for tracking referrals from the criminal justice system, limits on SUD services imposed by Medicaid MCOs and insurance carriers);

b. access indicators (such as counts of number of individuals who received SUD treatment services by key demographic information including age, race/ethnicity, pregnant, non-English-speaking, veterans, etc.);

c. process indicators (such as proportion of potential clients who show up to first appointment, wait times, proportion of clients who receive transportation vouchers/assistance, proportion of clients who end treatment by completion or transfer);

d. client perceptions of care indicators in addition to the data already gathered in the outcome evaluations (collecting client feedback in a systematic and anonymous manner during treatment and at program exit); and

e. outcomes collected by SUD programs as clients exit (such as percent of clients with no arrests since admission, percent of clients who are abstinent at program exit, percent of clients who have stable housing at program exit, percent of clients who are employed at program exit).

(5) Where can program policy or targeted funding changes make the most difference for SUD program client barriers?

Client motivation was a frequently mentioned barrier by providers and consumers. Clients' motivation to work toward recovery and participate in SUD programs can be undermined by several key factors including resource deprivation, lack of support for recovery, and program-level barriers. When an individual is struggling to meet basic needs such as shelter, food, safety, and experiencing disconnection from friends and family, they may have greater difficulty with the tasks needed to address addiction. Vulnerable individuals with substance use disorders, such as those transitioning out of jails or prisons, may have more limited internal and external recovery resources and these resources are thought to play an important role in SUD program initiation, maintenance, and longer-term recovery. At the same time, clients with significant resource deficits can overwhelm traditional SUD treatment programs because program resources are often limited.

As noted in the background of this report, client resource barriers interfere with their ability to engage in SUD programs. Behavioral changes are difficult to take on for everyone, but people in recovery are often working on changing their behavior while also coping with mental health problems, trauma, and legal issues, all while balancing program appointments, requirements, and paperwork in the face of maintaining their "regular" life responsibilities (e.g., employment, housing, children, and other family responsibilities). Compounding these issues with negativity and stigma from others, clients can become overwhelmed and frustrated. Thus, support for basic resources may be crucial to successful program engagement and sustained recovery.

Another barrier noted throughout the staff and consumer surveys was related to program and staff quality, although fewer program staff mentioned these barriers compared to consumers. Consumers mentioned experiences of being treated like a number, feeling that they were only there for program financial reasons, or being exploited in other ways. Additionally, over half of both staff and consumers indicated that clients who do not take the program seriously are a barrier for program engagement for other clients. A better understanding of how some clients may act in ways that are disruptive to their peers is needed to target changes in program policies and strategies.

When clients relapse while in the program, it can endanger the recovery of other clients and make other clients feel they are not taking the program seriously. For these reasons, some programs heavily sanction or terminate these clients when they relapse. In other cases, it is not due to the SUD program policies but rather the criminal justice system that has mandated the client's participation in SUD program with specific rules and procedures regarding relapses. Staff mentioned this as a significant barrier to client engagement in SUD programs.

Recommendations for consideration of next steps

1. Facilitate program engagement starting at the first call by standardizing protocols and educating staff on the importance of that first phone call.

2. Identify all personal, program, and systemic barriers to SUD programs regularly. It is estimated that around 80% of consumers disengage from SUD program before clients complete 30 days of the program. One option, to more fully document all barriers, might be to use key informants as mock consumers to "walk-through" and map entry into the program to identify barriers at each step in the process.

3. Capitalize on the science of engagement and motivation by encouraging client choices where possible (autonomy), increasing client feelings of competence (e.g., skills building, helping with basic resources), and helping build community and supports for clients. Obtaining feedback from clients about resource needs and program efforts to support those needs may also be helpful.

4. Provide opportunities for clients and consumers to provide timely, consistent, and anonymous feedback regarding barriers to engagement, acceptable ways to address their needs, and to ensure program approaches are working particularly for the most vulnerable clients.

5. Efforts are needed to ensure peer support workers, which play an important role for SUD programs and clients, have the needed training, education, supervision, and support for peer support persons, as well as with clinical staff about the role of peer support so that peer support workers are not overburdened, overwhelmed, or put into situations that are outside of their appropriate role.

6. Continue collecting client feedback and outcomes 6-12 months after intake in ways that encourage honest reporting of recovery status. These procedures include: (a) random, not targeted, selection into the follow-up sample; (b) follow-up interviewers are not linked to any program (conducted by University of Kentucky CDAR staff); (c) confidentiality protections based on federal regulations that are reviewed and approved by the University of Kentucky Human Subjects Review Committee each year such as having a Federal Certificate of Confidentiality; (d) extensive interviewer training and supervision; (e) staff that are devoted to the follow-up studies Sunday through Thursday evenings; and (f) high follow up rates.

7. Standardize and track key program performance indicators and make them more transparent. Additional efforts to broaden the utility and implementation of performance indicators for SUD treatment are recommended. Increasing dissemination of the findings to the various stakeholder groups that would be interested in the findings but are not currently receiving them is a worthwhile effort to pursue in advancing the utility of Kentucky's performance measurement of SUD programs.

8. Alternative responses to relapse should be explored that can protect other clients from the harms of substance use in their proximity while allowing for clients to stay involved in the program, and working toward recovery, even when relapses occur.