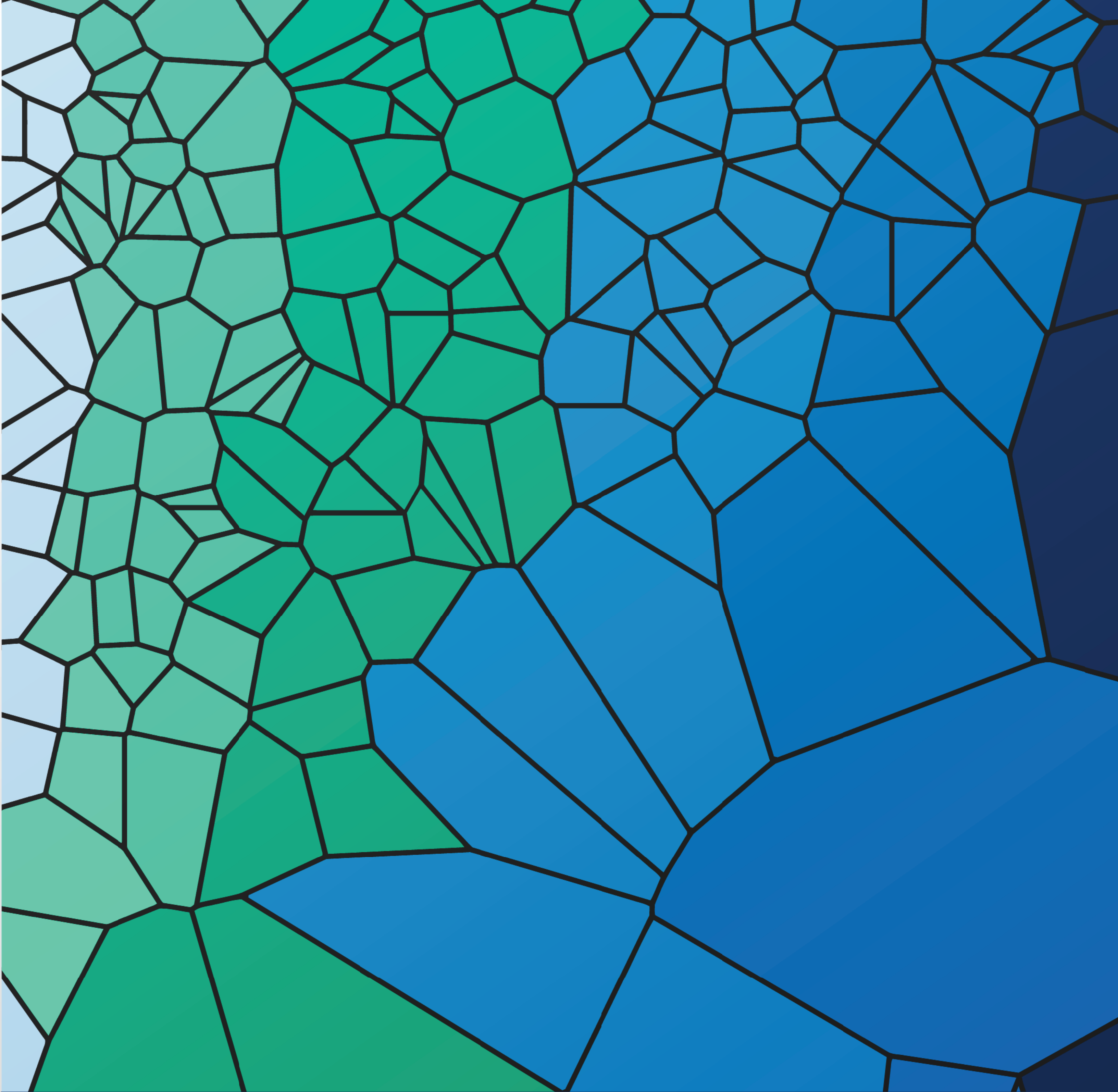

What Do Providers Say About **Client Barriers to SUD Program Engagement?**

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Acknowledgments

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Executive Summary

Background

Although not all individuals with substance use disorders (SUD) enter SUD programs, SUD programs have been helpful for individuals in their recovery journey. However, there are a number of barriers to SUD program engagement. Consumers can experience personal barriers such as the lack of motivation for recovery. Another personal barrier is the lack of resources such as stable housing or transportation which can make SUD program engagement more challenging. However, consumers can also experience systemic-level or program-level barriers. Because the systemic and program-level barriers could be addressed with more targeted funding or with policy or practice changes, it is important to identify and document them. This survey examined provider perceptions of personal, program, and systemic barriers to client engagement in SUD programs as well as organizational barriers that make it more difficult to effectively work with SUD clients. The Provider Survey (i.e., Project 2) was one of four research projects undertaken by UKCDAR in 2023 to document the barriers to SUD program entry and engagement.

Method

Provider surveys were targeted to staff from: (1) Community Mental Health Centers (CMHC); (2) Recovery Kentucky Programs; (3) prenatal programs (identified because they received specialized funding from the Kentucky Office of Drug Control Policy); and (4) Department of Corrections (DOC) programs Substance Abuse Programs (SAP) programs in jails, prisons, community custody and Social Service Clinicians in the community). The provider survey content was informed by the research literature and a prior study of barriers to working with SUD clients with staff from Kentucky CMHCs (Logan, Scrivner, Cole, & Walker, 2018). Additionally, the content was informed by a community advisory board meeting with individuals who have used substances and who have a variety of experiences with SUD programs (October 24, 2022).

Surveys were collected from February 20, 2023 to April 11, 2023. The total surveys with complete and valid responses were done with 966 staff. Of those, 133 (13.8%) reported they worked at programs that did not fit into the specified programs (i.e., were not CMHCs, Recovery Kentucky programs, prenatal programs listed, or DOC programs listed), leaving a final sample of 833 analyzed for this report.

Demographic Information

The majority of the respondents were affiliated with CMHCs (n = 615), followed by Recovery Kentucky programs (n = 130), prenatal programs (n = 53), and DOC SAP programs or Community Social Service Clinician (SSC)s (n = 35). Specific program response rates are provided in Appendix A.

The sample was mostly women (75.2%) and 39.1% had less than a bachelor's degree, over a quarter had a bachelor's

degree (28.8%), and about one-third had a master's degree or a higher level of education. Half of the sample (49.1%) indicated they had professional licensure. Overall, 11.3% had worked with SUD clients/programs for less than a year, 20.5% had worked with SUD clients/programs from 1-2 years, 48.3% worked with SUD clients/programs between 3 and 10 years, and 19.9% had worked with SUD clients/programs 11 or more years. Also, about two-fifths of the sample (41.4%) reported they were currently in recovery.

The majority of the sample (71.5%) reported they worked directly with SUD clients between half the time to all of the time. Respondents reported they primarily served both rural and urban clients (60.9%) or rural clients (35.8%) while very few indicated they primarily served urban clients (3.4%).

Results

Survey results are divided into five main sections including provider perceptions of: (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. Results are provided by the four program types and overall.

Client Barriers to SUD Program Engagement

Although respondents indicated that individuals with co-occurring mental illness, younger adults (18-24 years old), women, individuals who are homeless, and individuals who do not have insurance have the most difficulty engaging in SUD programs, they were not the same groups that respondents thought they or their organization could better serve. Respondents thought that they or their organization could better serve non-English speaking clients, adolescents (11-17 years old), persons on active duty in the military and their families, veterans, seniors/older adults (55+), pregnant and post-partum women, LGBTQ+ individuals, racial/ethnic minorities, and clients with co-occurring vulnerabilities other than mental health (e.g., physical, mental, developmental, or learning disabilities, chronic pain).

When considering specific barriers to program entry, personal barriers (e.g., concerns about being separated from children, embarrassment, and motivation) were the highest rated overall, on average. The next highest rated were program and resource barriers and adaptability barriers or lack of adaptation to client needs (e.g., clients having severe mental health problems, physical disability or chronic health problems). Closely following that were accessibility barriers. Program quality barriers were the lowest rated overall (e.g., concerns about judgment from staff, knowledge of program staff, quality of peer support workers or peer-led services).

However, the significant barriers for staying in treatment were somewhat different than the significant barriers for entering programs. About four-fifths (82.0%) of the respondents rated at least one program, resource, or personal barrier as a significant barrier (between 4 and 7). Similarly, about four-fifths (82.8%) of the respondents rated at least one of the support

barriers as a significant barrier, suggesting that support for recovery and for program participation is crucial to client engagement in the program. Three-quarters of respondents rated at least one of the adaptability barriers as a significant barrier and two-thirds of respondents rated at least one of the accessibility barriers as a significant barrier. Similar to program entry, program quality barriers had the fewest participants (50.9%) who rated at least one of the barriers as a significant barrier.

About one-third of respondents reported they had heard about clients being exploited or not treated well in SUD programs including being treated unfairly or differently from other clients, financial or labor exploitation, and program quality issues.

Just over one-quarter of respondents indicated they believed SUD programs had restrictions that impact SUD engagement such as relapse termination or punishment (even though relapse is part of recovery), requiring a negative or a positive drug screen for entry, program approach, and lack of flexibility of the program to meet client needs.

Challenges to Working with SUD Clients

Almost all respondents indicated challenges in working with clients were associated with client level barriers (e.g., motivation and relapse) rather than experiencing agency-level barriers as challenges in working with SUD clients.

Although the majority of respondents believe clients graduate or complete treatment frequently or very frequently (71.8%), many respondents also indicated clients drop out or are unable to proceed with the program because they missed too many appointments or because of their involvement with the criminal justice system.

Almost all of the respondents indicated they recommend peer support workers to work with SUD clients (93.8%) and that there are a variety of benefits in having peer support workers mostly for the current clients but also to help staffing and duties related to the overall program. Closely related, many respondents (71.2%) indicated their program hires former clients and most of them are hired into the peer support workers role. Benefits mentioned for hiring former clients overlap with benefits of peer support workers and include being able to build rapport more easily and serving as role models for current clients.

The most frequently mentioned concerns about peer support workers as employees and hiring former clients also overlap and center around concerns about blurred boundaries, relapse risk or employment being tied to recovery, a lack of training or education, and the need to train and closely supervise them, which requires human resources.

Organizational Challenges and Rewards Experienced by Program Staff

The most frequently mentioned organizational challenges were related to staffing shortages, high workloads, and burnout while the

least mentioned challenges were associated with harassment of clients by other clients or staff, exploitation of clients, difficulty getting time off, and the agency or program not treating clients or staff very well.

Over half of respondents (58.3%) indicated there were lingering impacts from COVID. The most frequently mentioned COVID impacts included telehealth and Zoom meetings with clients and staff, and lower client attendance and engagement. Next most frequently mentioned were COVID protocols and health issues or concern about health.

Overall, the respondents who participated in the survey were largely satisfied with their job and had a low burnout rating, which is interesting given the frequency with which staff burnout was mentioned by respondents as an organizational challenge.

Most of the respondents reported the best aspect of their job was helping to make meaningful changes in clients' lives (62.9%) and one-fifth mentioned contributing to positive changes in society (21.6%) was the best aspect of their job.

Key Program Performance Indicators

Although the majority of respondents indicated their program or agency tracked the number clients who enter the program (82.1%), around two-thirds indicated their program or agency tracked a variety of other indicators. Additionally, of respondents who indicated their program or agency tracked client engagement, service, or client feedback and outcomes, about half of them said the information was shared with staff and about half said it was not shared widely. Half or less than half indicated their organization tracked client demographics. When asked about the most important program indicators, client-level outcomes such as relapse and aftercare engagement were most frequently mentioned, then program completion and attendance indicators, program-level indicators, and least frequently mentioned was client feedback (14.9%).

Staff indicated that clients seek SUD programs that match their preferences in some way including program approach, help or support with basic resources, and program length. Program quality and accessibility were less frequently thought to be criteria for consumers' selection of programs.

Services Provided for Clients

The vast majority of respondents, regardless of program, reported their program/agency conducts comprehensive assessments, personalizes treatment plans and offers a variety of services and resource supports, and they do discharge planning with some or all clients. Over half of the respondents (58%), overall, indicated that while clients are waiting for a SUD appointment their organization offers interim services. About one-third of respondents indicated what kind of interim services are offered during the waiting period and those services included referrals to other agencies or community services, putting clients into a different level of care than needed as a beginning, referring or telling clients about detox,

stabilization at the hospital, or crisis lines/services. Referring clients waiting for an appointment to peer services, AA/NA, and case management were infrequently mentioned as something done for clients while waiting for an appointment.

Most, if not all, programs have access to a language interpretation line to serve non-English speaking clients, but on-site language services are less common, with around half having sign language services and one-third having staff counselors who speak languages other than English.

Additionally, around three-quarters of clients indicated that peer support workers, trauma education and safety planning, Naloxone and overdose education, assessments of recovery needs, AA/NA, and help with employment are offered both during the program and as part of after care for some or all clients.

About two-thirds of respondents indicated their agency provides or allows for MOUD/MAT services with lower rates reported by Recovery Kentucky and DOC staff than for the other two types of programs.

When asked about practices to increase client engagement, the most frequently mentioned as being implemented in the past year were expanding treatment options (23.3%) and the use of specific treatment strategies (24.6%). The hiring of staff with specialized skills (e.g., Spanish speaking staff, 49.3%) and being flexible with appointment times (25.7%) were most frequently mentioned as not being implemented at all in their program/agency.

The majority of respondents indicated they used relapse prevention and peer support workers in their program. Additionally, respondents indicated they or their organization offered between 5 and 9 specific mental health evidence-based practices. They also reported an average of 5 challenges with using evidence-based practices such as lack of training, limited time to learn or refresh evidence-based practices, lack of confidence, and concern with clients accepting some of the evidence-based practices they thought might be useful.

Most respondents agreed that for both smoking cessation and harm reduction options, client needs and preferences should be considered a priority. Additionally, the greatest proportion of respondents thought that injection supplies are not offered and should not be offered (40%-45%) in their program while Pre-exposure prophylaxis (PrEP) was the next most frequently mentioned as not being offered (and should not be offered) in their program (28.7%). In contrast, 48.7% of respondents reported that PrEP is offered in their program and should be offered. The most frequently mentioned harm reduction services that are, and should be, offered are Naloxone kits and training (72.7%), safe sex education (46.5%) and fentanyl tests (41.9%).

Conclusions and Recommendations

Because of providers' vantage point of working within the systematic and programmatic constraints and resources, their perspective is less focused on individual experiences. Rather, provider experiences give a

broader perspective and include the experiences of many clients as well as a more in-depth understanding of organizational and workforce issues that impact the accessibility, availability, and adaptability of SUD services. For this reason, providers in a variety of publicly-funded SUD programs were surveyed about their perceptions of clients' barriers to SUD program engagement as well as their own barriers to working with SUD clients.

Overall results of the provider survey show that respondents consistently ranked clients' personal barriers such as lack of motivation as more significant than systemic or program level barriers. However, personal barriers can be impacted by systemic, program, and resource barriers, which may be less apparent to individuals who are not directly experiencing them (i.e., less apparent to providers than to clients).

Client resource barriers such as lack of stable and safe housing, transportation problems, social support, and difficulty meeting basic needs were frequently mentioned as barriers to SUD program engagement. Research suggests that clients who come into SUD programs with fewer resources are less likely to complete the program and they are more likely to relapse and have other negative recovery outcomes (e.g., criminal justice system involvement, sustained economic vulnerability, mental health problems) (Logan & Cole, 2023; Logan, Cole, & Schroeder, 2022; Logan, Cole, & Walker, 2020; Logan, McLouth, & Cole, 2022). The complex and persistent interplay of poverty, racism, gender-based violence, community violence, stigmatization of SUDs results in reduced employment opportunities, less stable housing, greater vulnerability to physical and mental health conditions, and social alienation and isolation. Recovery encompasses all aspects of an individuals' life, as noted in one of the guiding principles of recovery (i.e., "recovery is holistic") in SAMHSA's working definition of recovery (SAMHSA, 2012) Meaningful connections between service systems that can help with these interwoven social problems are needed to provide clients with the resources, safety net, and support to facilitate significant progress in their recovery.

Additionally, one-third of staff reported hearing about negative experiences clients had with SUD programs in the past. As shown in the data tables from the Performance Indicators Project Report, just over one-half (54.3%) to two-thirds (67.7%) of individuals coming into treatment programs and who participated in one of three studies (KTOS, RCOS, CJKTOS) have been in SUD programs prior to program entry. Thus, program barriers that may seem minimal to staff working in the programs may have a more negative impact on clients with prior negative experiences.

Both systemic factors and the way relapse is handled within a program can interfere with program engagement and recovery. Systemic barriers such as the cost of treatment, limitations imposed by insurance, and legal issues can increase client stress and reduce program engagement. These factors can also interfere with staying in a program. Additionally, sanctions and termination because of relapse were noted as a particularly

concerning challenge to working with clients because relapse is a part of recovery and punishing clients for relapse may set them back unnecessarily.

Staff may also face a number of challenges to working with SUD clients such as staff shortages, high caseloads, challenges to implementing evidence-based practices, and burnout. Addressing staff challenges may help them better support and engage clients. One way to do this may be to gather staff feedback in a systematic way that also encourages them to speak openly about their challenges. Additionally, providing staff with opportunities and resources to expand their skills and education can be rewarding in multiple ways.

Peer support workers were overwhelmingly noted as being extremely helpful to clients. Additionally, providers mentioned several key benefits for peer support workers themselves, for current clients who have access to peer support workers, and to the program itself in that peer support workers help with clients, but they are also able to take on tasks that other staff cannot. Several key concerns related to peer support workers were also mentioned including the need to support them in meaningful ways, the importance of educating them and providing them with skills training, and the need for supervision.

Most staff rated client-level outcomes or program success as the most important program performance indicators while only a few mentioned client feedback. Perhaps past efforts at obtaining client feedback have not been very informative because client satisfaction surveys are notoriously biased toward positive results. The conditions under which client feedback is collected have an impact on the results. The most honest feedback is provided in contexts when potentially negative feedback will not jeopardize relationships or be perceived as having negative repercussions for the client. Thus, anonymous or confidential methods for collecting client feedback are important for reducing bias in responses. Furthermore, without a systematic way of collecting feedback from all/most clients, the individuals who volunteer to provide feedback tend to be the individuals with the most extreme experiences because they are the most motivated to share their perspective: the most satisfied and the least satisfied. Thus, collecting feedback in a systematic and regular manner may be key to gathering a more accurate view of the range of clients' experiences.

When asked what staff believed consumers consider in selecting a SUD program, the majority indicated clients look for program approach and length while quality and accessibility were thought to play a lesser role in selection. The fact that providers believe that program quality plays a lesser role in consumers' selection of programs may be more a product of the difficulty of obtaining this information than the usefulness of this information if it were available to potential consumers. Increased education for consumers about program approaches, quality, and success is important in helping them find the right match to the program. Finding the right match is a challenge under the best of conditions, but

attempting to do this without useful and accurate information is even more difficult. Clients entering programs that are not a good fit for them will increase the likelihood that they will disengage or have poorer outcomes. Each failed experience can undermine a person's sense of hope and self-efficacy that recovery is possible for them. Hope plays an essential role in recovery; according to SAMHSA's (2012) working definition, "Recovery emerges from hope" and "Hope is a catalyst for recovery." Thus, actions that SUD programs and providers can take to facilitate clients' appropriate match to treatment/programs to maximize the likelihood of success should be implemented. Additionally, helping clients with what to expect from a program when they first make an appointment could also help clients better adjust and prepare themselves for the specific program they have selected.

One group of barriers that may need particular attention are the adaptability barriers. In addition to client needs and preferences, clients may have special circumstances that need to be considered in SUD programs including mental health problems, physical health problems, disabilities, criminal justice system involvement, or being a part of a marginalized group (e.g., race/ethnicity, LGBTQ+). For example, racial diversity is lower in the KTOS and RCOS samples than in the general population of Kentucky (US Census Bureau, 2023). However, it's important to note that the proportion of clients who are racial/ethnic minorities varies significantly by CMHC region and the counties in which the Recovery Kentucky programs are located. For example, CMHC regions with the highest percentage of clients reporting at intake their race was other than White include: Four Rivers Behavioral Health (14.0%), Seven Counties, Inc. (14.6%), LifeSkills, Inc. (12.6%), Communicare, Inc. (12.4%), and New Vista (11.8%). Given the variability of racial diversity in different regions of the state, close attention to the racial make-up of clients in regions should be monitored at the regional level to determine if there are disparities in entering and staying in SUD programs by racial groups. Also, the KTOS, RCOS and CJKTOS data from Project 1 show that only 15%-19% of clients that come into those programs are 18-25 years old and only 7.0%-11.4% are ages 50 and older, meaning a significant portion of consumers in the younger and older age groups of adulthood may be struggling with addiction on their own. Innovative strategies need to be developed to engage persons of racial minorities and younger and older age groups.

Most staff indicated that abstinence-based versus harm reduction should be decided depending on the client needs and preferences, which is consistent with one of the guiding principles of recovery: "recovery occurs via many pathways" (SAMHSA, 2012). Nonetheless, some staff had strong and conflicting opinions about which approach is best as well as about specific harm reduction strategies that should be incorporated into SUD programs.

Several recommendations were developed based on the provider survey results. First, addressing systemic, program, and resource barriers may be a pathway to increasing client engagement by reducing interference with staying

in a program as well as to increasing motivation for recovery and engaging in the program. At the very least, it may be helpful for clients if staff acknowledged the challenges clients face with getting to and staying in the program. Assessing or offering ongoing support directly or through referrals could help clients as needs and barriers may change over time. Regular check-ins with clients about their potentially changing needs and resources, if they are not already occurring in the course of treatment, may improve the responsiveness of SUD programs to clients.

Second, programs could more widely share information that is tracked about the program to their own staff. In particular, clients should have an opportunity to provide feedback to program administrators and staff on various aspects of their experience including the use of evidence-based practices, particularly given that about two-thirds of staff thought a challenge to using evidence-based practices is client acceptance.

Third, it is important to recognize and acknowledge that staff are sometimes divided about the best approaches to SUD programs, although the majority of respondents agree that it is important to meet the client where they are with regard to smoking cessation as well as using harm reduction strategies to support recovery. Whatever the program focus is, clients should be educated about what to expect so they can choose a SUD program approach that fits their needs and preferences. Having educated choices in program selection may help clients with motivation to stay engaged with the program and their recovery.

Fourth, peer support workers provide a valuable service in SUD programs. Agencies experience high staff turnover, high caseloads, and must operate within strict and constraining billing regulations; thus, there is an incentive to turn to peer support workers to fill in gaps that may not be appropriate for their expertise and training. Considerable investment and effort need to be put into training, education, supervision and support for peer support workers, as well as with clinical staff about the role of peer support workers so that they are not overburdened or put into situations that are outside of their appropriate role. Additionally, it is important to have a program culture and options for peer support workers who are struggling with their own recovery to be honest and open with their supervisors without fear of losing their employment.

Fifth, more creative and innovative strategies need to be considered to address specific client needs, vulnerabilities, and preferences within the same program and more education for clients in selecting specific programs approaches within their resource constraints (e.g., location or distance to travel, time conflicts). Greater flexibility in approaching a client's recovery with a harm reduction approach versus abstinence-only may be possible in outpatient counseling in a way that would be more difficult to implement in group-based settings such as residential and intensive outpatient treatment. In other words, a therapist meeting for individual counseling with clients may have greater flexibility in working with multiple clients with very different approaches.

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Background

Despite significant efforts to address substance use disorder (SUD) in the United States, overall prevalence rates of substance use disorders have remained largely stable or have increased in recent years. For example, in 2021 it was estimated 46.3 million individuals aged 12 or older met DSM diagnostic criteria for a substance use disorder (SUD) in the past year in the United States (Substance Abuse & Mental Health Services Administration, 2022). This estimate was higher than in the 2020 report that estimated 40.3 million people had a SUD in the past year (Substance Abuse & Mental Health Services Administration, 2021).

A minority of people with substance use disorders (SUD) enter SUD programs. However, SUD programs are helpful for individuals in the recovery journey. For example, one study found that adults who reported any SUD program exposure were nearly twice as likely to be in recovery compared to individuals who used substances but who had no exposure to SUD programs (Jones, Noonan, & Compton, 2020). However, there are a number of barriers to SUD program engagement particularly for vulnerable populations. Barriers can be conceptualized in categories that include personal barriers such as motivation for recovery. Individuals with significant resource deprivation such as lack of stable housing and limited transportation options also may find engaging in SUD programs more challenging (Logan, Cole, & Walker, 2020). Consumers can also experience systemic-level or program-level barriers. Because the systemic and program level barriers could be addressed with more targeted funding or with policy or practice changes, it is important to identify and document them.

Although there have been numerous studies conducted with SUD treatment clients, there has been less attention to individuals working with SUD clients on a daily basis in Kentucky. Providers have a different perspective than clients, less focused on the particulars of an individual's experiences with a broader view of the experiences of many clients as well as a more in-depth understanding of organizational and workforce issues that may impact the accessibility, availability, and adaptability of SUD services. This survey examined SUD provider perceptions of personal, program, and systemic barriers to client engagement in SUD programs as well as organizational barriers that make it more challenging to effectively work with SUD clients. The Provider Survey (i.e., Project 2) was one of four research projects undertaken by UKCDAR in 2023 to document the barriers to SUD program entry and engagement.

Although there have been numerous studies conducted with SUD treatment clients, there has been less attention to individuals working with SUD clients on a daily basis in Kentucky.

Method

Provider surveys were targeted to staff from: (1) Community Mental Health Centers (CMHC); (2) Recovery Kentucky Programs; (3) prenatal programs (identified because they received specialized funding from the Kentucky Office of Drug Control Policy); and (4) Department of Corrections (DOC) programs (SAP programs in jails, prisons, community custody and Social Service Clinicians in the community). Surveys were collected from February 20, 2023 to April 11, 2023. At the beginning of February, program directors were notified via email of the provider survey by state stakeholders. On February 20th all CMHC directors, Recovery Kentucky program directors, the DOC Division for Addiction Services director, and directors for the four prenatal programs were asked by email to forward information about the purpose of the study and a link to the provider survey to their staff. On February 27th staff persons who participated in collecting information for ongoing state-supported SUD program outcome evaluations (e.g., KTOS, RCOS, and AKTOS) were emailed individually (n = 1,900 emails). On March 16th, program directors as well as individuals who participated in collecting information for state outcome evaluations but who had not already completed the survey were reminded, by email, about the provider survey (n = 1,600 emails). The administrators and program directors involved in DOC programs were also reminded via email of the provider survey opportunity again. On March 23rd, program administrators with low staff participation were contacted by phone and email to remind them to let their staff know about the provider survey opportunity. Specifically, CMHCs with fewer than 20 survey responses, Recovery Kentucky programs with fewer than 5 responses, and prenatal programs with no or only a few responses received additional follow up contact.

The provider survey content was informed by the research literature and a prior study of barriers to working with SUD clients with staff from Kentucky CMHCs (Logan, Scrivner, Cole, & Walker, 2018). Additionally, the content was informed by discussion in a meeting on October 24, 2022, with the SUPRA Survivors Union of the Bluegrass, a community advisory board of individuals engaging in active use convened through the HEAL initiative and who have a variety of experiences with SUD programs. The informed consent script at the beginning of the online survey told respondents: “We are asking about your thoughts to learn more about organizational and other barriers to entering and engaging in substance use disorder (SUD) programs as well as barriers to working with SUD clients from your perspective. We are focusing on barriers that could be addressed through organizational changes and/or targeted funding. The survey also asks about what services your organization offers and what and how your organization tracks performance indicators. The survey also asks about work stressors and positive aspects of your job. The information will be used to help inform policies, practices and funding to serve more clients and address their individual needs.”

The survey took, on average, about 45 minutes to complete. Because of the survey length, it was likely staff completed the survey on personal time. Thus, respondents were offered three different payment options: (1) no payment; (2) UK travel mug; (3) $50.00 Amazon e-gift card (94.4% chose this option). The UK travel mug option was included because some positions did not allow staff to take monetary payment. Respondents who chose the travel mug or the e-gift card were asked to provide employment information, which

was verified for SUD program employment as well as determining if the respondent had already completed a survey.

Overall, 1,043 completed surveys were submitted. However, 56 were invalid entries (16 did not have verifiable SUD program employment, 38 were duplicates, and 2 individuals asked to withdraw their survey responses). After screening the data, 21 had responses that were not valid and were removed from further analysis leaving a sample of 966. Of those, 133 (13.8%) reported they worked at programs that did not fit into the targeted (i.e., they were not employed at a CMHCs, Recovery Kentucky program or the specifically targeted prenatal programs or DOC programs), leaving a final sample of 833 responses that were analyzed for this report.

The data are provided in tables by program type and overall. Because the sample sizes vary for the four different programs, no statistical analysis was conducted to compare by program type. The data displayed are for descriptive purposes. Responses to open-ended questions were theme-coded by the research team. Quotes from respondents are used throughout the report to highlight themes for open-ended responses. Minor changes were made to the quotes for confidentiality and clarity.

Demographic Information

The sample was composed predominately of women (75.2%) while a smaller proportion were men (22.4%) or they identified as other than male or female or preferred not to say (2.4%). The average age of the overall sample was 41.4 (ranging from 20-85) and 93.0% identified as White, 6.0% identified as Black, 1.0% identified as Hispanic or Latino, and 1.0% identified as another race/ethnicity. Almost one-third of the sample had a master's degree (31.2%) or doctorate (0.8%) and over a quarter had a bachelor's degree (28.8%) while 39.1% had less than a bachelor's degree. About half of the sample (49.1%) indicated they had professional licensure.

Overall, 11.3% had worked with SUD clients/programs for less than a year, 20.5% had worked with SUD clients/programs from 1-2 years, 48.3% worked with SUD clients/programs between 3 and 10 years, and 19.9% had worked with SUD clients/programs 11 or more years. Also, about two-fifths of the sample (41.4%) reported they were currently in recovery. Among those in recovery, they reported they had been in recovery an average of 8.1 years (ranging from 0.5 to 45 years).

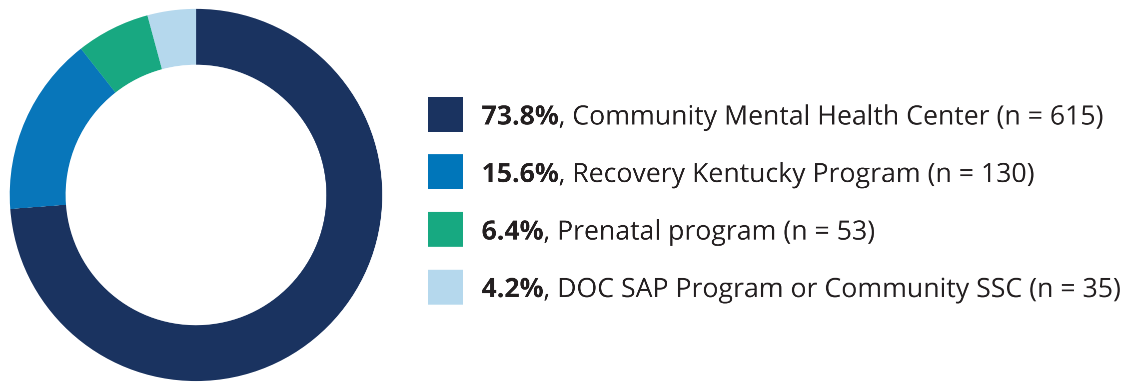
Program Information

As Figure 1 shows, the majority of respondents were affiliated with CMHCs (73.8%), followed by Recovery Kentucky programs (15.6%). Specific region/program response rates are provided in Appendix A.

The programs that are profiled throughout the results are all very different from each other. For example, the CMHCs offer a variety of services for SUD clients while the Recovery Kentucky programs are residential programs that are peer led (social model of recovery), rely on AA/NA model of recovery, and do not provide counseling directly but

rather link clients with community-based services. The prenatal programs offer a variety of services for pregnant women as well. The DOC program results include providers that work in jail (2.9%) or prison (34.3%) SAP programs as well as individuals working as community social service clinicians (62.8%). The community social service clinicians do not provide SUD services directly but rather assess and link clients to SUD services.

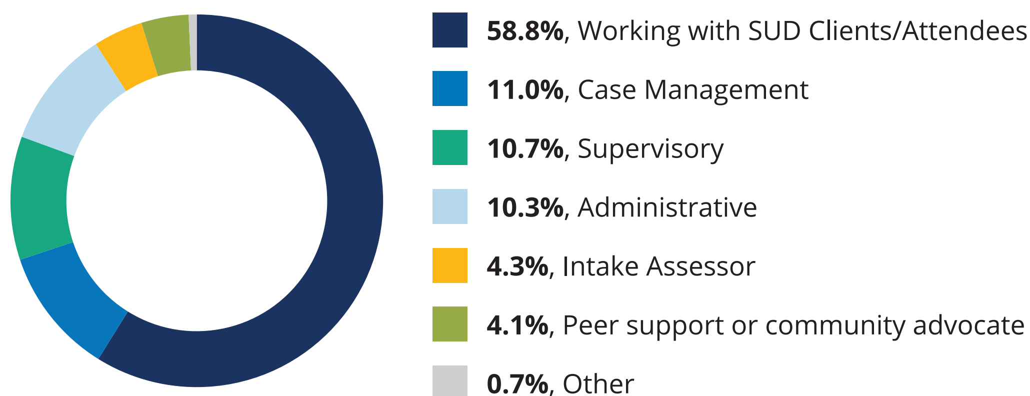
FIGURE 1. AGENCY DISTRIBUTION OF PARTICIPANTS (N = 833)



Respondents reported they primarily served both rural and urban clients (60.9%) or rural clients only (35.8%) while very few indicated they primarily served urban clients (3.4%).

As shown in Figure 2, most of the respondents reported their job was primarily working with SUD clients (58.8%) while around 10% indicated they were in each of the following positions: case manager, supervisory, and administrative positions. Additionally, 4.1% worked as peer support workers or as a community advocate and 4.3% worked as an intake assessor or specialist.

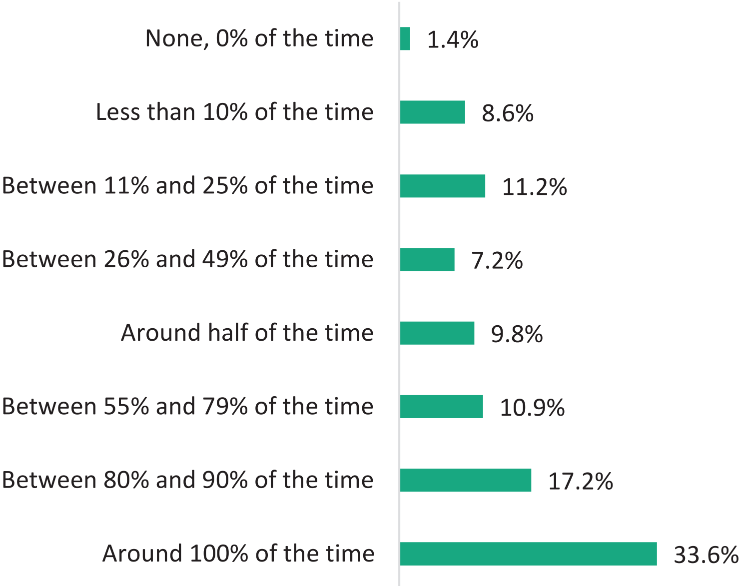
FIGURE 2. PRIMARY ROLE IN SUD PROGRAM (N = 833)



Note. Percentages add to 99.9% because of rounding error.

Figure 3 shows that the majority of the respondents (71.5%) work directly with SUD clients between half the time to all of the time.

FIGURE 3. TIME SPENT WORKING DIRECTLY WITH SUD PROGRAM CLIENTS (N = 833)



Note. Percentages add to 99.9% because of rounding error.

Results

Survey results are divided into five main sections including provider perceptions of: (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. Results are provided by the four program types and overall.

Section 1. Client Barriers to SUD Program Engagement

This section provides results for questions about staff perceptions of: (a) populations that have the most difficulty entering and staying in treatment; (b) populations that could be better served by programs; (c) client barriers to entering SUD programs; (d) client barriers to staying in SUD programs; (e) experiences of client exploitation in SUD programs; and (f) program restriction barriers for engaging clients in SUD programs.

Populations That Have the Most Difficulty Entering and Staying in Treatment

As Table 1.1 shows, program providers most frequently mentioned individuals with co-occurring serious mental illness (28.6%), younger adults (ages 18-24, 26.8%), women (22.1%), individuals who are homeless (21.7%) and/or who have no insurance (21.2%) as having the most difficulty entering or staying in SUD programs. Less frequently mentioned included individuals who were using MOUD/MAT (7.9%), had no legal or child protective service involvement (7.4%), were physically disabled (7.1%), were non-English speaking (7.0%), and hearing impaired (1.2%).

Within each program type results differed slightly with CMHC providers indicating that individuals with co-occurring serious mental illness, younger adults and individuals who are homeless have the most difficulty with SUD program engagement. For Recovery Kentucky staff individuals with co-occurring serious mental illness, younger adults, and individuals with chronic health problems were most frequently mentioned as having difficulty with SUD program engagement. For prenatal program staff, they mentioned most frequently that pregnant women, individuals with co-occurring disorders, younger adults and individuals with no insurance struggled with SUD program engagement. For DOC staff, individuals with co-occurring disorders, serious mental illness, and individuals mandated to treatment were most frequently mentioned as having difficulty with SUD program engagement.

TABLE 1.1. POPULATIONS WITH THE MOST DIFFICULTY ENTERING AND STAYING IN SUD PROGRAMS

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
More frequently mentioned by respondents					
Individuals with co-occurring serious mental illness	26.5%	36.2%	30.2%	34.3%	28.6%
Younger adults *(18-24)*	25.2%	36.9%	26.4%	17.1%	26.8%
Women	22.6%	23.1%	20.8%	11.4%	22.1%
Individuals who are homeless	25.4%	6.9%	20.8%	14.3%	21.7%
Individuals with no insurance	24.4%	6.2%	26.4%	14.3%	21.2%
Less frequently mentioned by respondents					
Men	15.6%	17.7%	13.2%	28.6%	16.3%
Individuals mandated to treatment *(e.g., court ordered, child protective services)*	17.4%	13.1%	9.4%	17.1%	16.2%
Pregnant women	14.8%	13.8%	37.7%	2.9%	15.6%
Individuals with chronic medical conditions	13.0%	22.3%	11.3%	22.9%	14.8%
Individuals with co-occurring disorders	14.8%	11.5%	7.5%	34.3%	14.6%
Adolescents *(11-17 years old)*	12.4%	10.0%	13.2%	5.7%	11.8%
LGBTQ+ *(sexual or gender minorities)*	11.9%	13.1%	9.4%	8.6%	11.8%
Individuals with extensive trauma histories or recent trauma/victimization	13.2%	5.4%	17.0%	2.9%	11.8%
Racial/Ethnic minorities	11.4%	13.8%	9.4%	0.0%	11.2%
Individuals who have been in prison/jail for several months or longer	11.2%	13.1%	7.5%	22.9%	11.8%
Older Individuals *(55 years old and older)*	10.7%	13.1%	9.4%	8.6%	10.9%
Individuals using medication for substance use (e.g., Suboxone)	6.5%	11.5%	7.5%	20.0%	7.9%
Individuals with no legal or child protective services involvement	7.0%	10.8%	5.7%	5.7%	7.4%
Individuals with physical or other disabilities	5.5%	13.8%	3.8%	14.3%	7.1%
Non-English speaking	7.5%	4.6%	7.5%	5.7%	7.0%
Deaf or hard of hearing	1.3%	0.8%	0.0%	2.9%	1.2%

Populations That Could Be Better Served by Programs

When providers were asked about which clients they believed could be better served by them or their program, the majority of respondents indicated non-English speaking individuals (70.9%), adolescents (11-17 years old, 65.5%), individuals in the military (57.1%), families of military personnel (51.9%), and older individuals (55 years old and older, 48.1%) (see Table 1.2). The most infrequently mentioned as needing service improvement included clients with DUI/DWI (27.0%), clients involved in the criminal justice system (27.7%), and clients who have experienced trauma (31.0%) and sexual abuse (32.4%).

When examining program differences, CMHCs staff had similar patterns of who they thought could be better served by their program as the overall pattern. However, Recovery Kentucky program providers also rated pregnant women (66.2%) relatively high as a group they could improve efforts to better serve. Many of the prenatal program staff indicated they could better serve men (69.8%).

The DOC providers had a very different pattern, than the overall pattern, for groups they thought they could better serve except for non-English speaking populations. More specifically, clients with co-occurring pain and SUDs (62.9%) and clients with mental or physical disabilities (68.6%) were more frequently mentioned as groups they (or their agency) could better serve. Individuals with trauma experiences (sexual assault, domestic violence, traumatic events) were also more frequently rated as needing improved services from DOC providers than those from the other programs.

TABLE 1.2. POPULATIONS THAT COULD BE BETTER SERVED BY SUD PROGRAMS

% Who Agreed or Strongly Agreed	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
More frequently mentioned					
Non-English speaking clients	70.9%	72.3%	67.9%	71.4%	70.9%
Adolescents *(11 – 17 years old)*	63.6%	74.6%	73.6%	54.3%	65.5%
Persons on active duty in the military	59.5%	50.8%	54.7%	42.9%	57.1%
Family members of persons in the military	54.1%	45.4%	43.4%	48.6%	51.9%
Seniors or older adults	50.4%	34.6%	52.8%	51.4%	48.1%
Pregnant or postpartum women	45.5%	66.2%	7.5%	42.9%	46.2%
Veterans	49.9%	30.8%	30.2%	48.6%	45.6%
Individuals who are LGBTQ+	50.1%	30.0%	20.8%	51.4%	45.1%
Clients with physical disabilities	44.2%	44.6%	37.7%	57.1%	44.4%
Clients with co-occurring pain and substance use	43.7%	50.8%	20.8%	62.9%	44.2%
Clients with mental or developmental disabilities	41.8%	49.2%	39.6%	68.6%	43.9%
Racial/ethnic minorities	47.3%	32.3%	18.9%	34.3%	42.6%
Clients with learning disabilities	41.8%	38.5%	34.0%	37.1%	40.6%
Less frequently mentioned					
Clients with limited education/literacy	41.5%	32.3%	32.1%	34.3%	39.1%
Clients with HIV or AIDs	43.1%	30.8%	18.9%	28.6%	39.0%
Young adults *(18 - 29 years old)*	41.3%	30.0%	13.2%	51.4%	38.2%
Clients who are homeless	42.4%	21.5%	20.8%	45.7%	37.9%
Clients with co-occurring mental health and substance use disorders	32.0%	42.3%	17.0%	54.3%	33.6%
Men	29.8%	38.5%	69.8%	25.7%	33.5%
Clients who have experienced domestic or partner violence	34.3%	33.8%	9.4%	51.4%	33.4%
Women	34.5%	38.5%	5.7%	31.4%	33.1%

TABLE 1.2. POPULATIONS THAT COULD BE BETTER SERVED BY SUD PROGRAMS (CONT.)

% Who Agreed or Strongly Agreed	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Clients who have experienced sexual abuse	32.7%	35.4%	9.4%	51.4%	32.4%
Clients who have experienced traumatic events	29.6%	39.2%	9.4%	57.1%	31.0%
Clients involved in the criminal justice system *(other than DUI/DWI)*	30.7%	24.6%	9.4%	14.3%	27.7%
Clients with DUI/DWI	29.9%	22.3%	11.3%	17.1%	27.0%

Client Barriers to Entering SUD Programs

When examining barriers SUD clients have when entering a program, respondents were presented with an extensive list of program and personal barriers and then were asked to rate the significance of the barrier on a scale ranging from 0-Not at all a barrier to 7-A significant barrier.

Because the list of barriers was so extensive, an exploratory factor analysis using principal factor analysis with a direct oblimin rotation (Floyd & Widaman, 1995) was used to examine overall factors. For program entry, the factor structure showed six factors initially but after examining the scree plot and the variance for each factor (i.e., the sixth factor accounted for less than 2% of the variance), a five-factor solution was examined. The Kaiser-Meyer-Olkin measure of sampling adequacy was .965 and the Bartlett's test of sphericity was significant ($p<.001$) and the five factors account for 61.2% of the variance (Williams et al., 2012).

Table 1.3 shows the average rating for each factor. The five factors included program and resource barriers (10 items, $r = .917$), accessibility barriers (5 items, $r = .847$), program quality concerns (11 items, $r = .923$), adaptability barriers (9 items, $r = .927$) and personal barriers (9 items, $r = .897$). The program and resource barrier factors were further broken down to examine program barriers (6 items, $r = .865$) and resource barriers (4 items, $r = .859$) separately.

Results show that personal barriers (e.g., concerns about being separated from children, embarrassment, and motivation) were the highest rated overall, on average. Next, highest rated were program and resource barriers and adaptability barriers or lack of adaptation to client needs (e.g., clients having severe mental health problems, physical disability or chronic health problems). Closely following that were accessibility barriers. Program quality barriers were the lowest rated overall (e.g., concerns about judgment from staff, knowledge of program staff, quality of peer support workers or led services).

Staff from the Recovery Kentucky programs had lower averages across each factor compared to the other programs. DOC providers had a higher average rating with adaptability barriers than the other three programs.

TABLE 1.3. AVERAGE RATINGS FOR FACTORS OF CLIENT BARRIERS TO ENTERING SUD PROGRAMS

Average Ratings for Factors (0-7)	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Program and resource barriers	3.1	1.6	2.8	2.9	2.6
Program barriers	2.8	1.7	2.8	2.9	2.5
Resource barriers	3.4	1.4	2.9	3.0	2.7
Accessibility barriers	3.0	1.5	2.9	2.5	2.5
Program quality barriers	1.6	1.1	1.8	1.8	1.6
Adaptability barriers	2.4	2.0	2.4	3.4	2.6
Personal barriers	3.8	2.8	3.6	3.5	3.4

Table 1.4 shows the specific barrier items grouped within each identified factor. For the purposes of discussion of the findings, scores of 4 – 7 for a specific item were operationalized as a "significant barrier."

Overall, 87.6% of staff rated at least one of the personal barriers as a significant barrier (between 4 and 7), 77.7% of staff rated at least one program and resource barrier as a significant barrier, 62.7% of staff rated at least one accessibility barrier, and 62.1% rated at least one adaptation barrier as a significant barrier, and just over half (51.3%) rated at least one program quality barrier as a significant barrier.

When examining specific barriers that were listed, about two-thirds of staff rated cost of treatment (68.5%) and concerns about separation from children or other vulnerable family members (65.4%) as a significant barrier. Over half of the staff also rated access to safe and affordable housing, lack of support, embarrassment, stigma, and lack of client motivation as significant barriers.

Fewer Recovery Kentucky staff rated program and resource barriers, accessibility barriers, and program quality barriers on the high end of the scale compared to staff from the other programs. Over half of program staff, from programs other than Recovery Kentucky, rated access to safe and affordable housing and transportation to the program as a significant barrier. For Recovery Kentucky, which provides supportive housing, homelessness or unstable housing needs are a priority for entering into the program. Over half of prenatal program staff rated bed availability as a significant barrier while fewer staff from other programs rated this factor as a significant barrier.

A high percentage of DOC program staff rated at least one of the accessibility and adaptability barriers as a significant barrier. Over half of program staff from the DOC programs rated program distance, lack of insurance coverage, having mental health problems, having a physical disability, being on medication for chronic mental or physical health problems, and lack of harm reductions options in SUD programs on the high end of the rating scale. High percentages of all program providers rated at least one of the personal barriers as a significant barrier. The highest rated barrier for Recovery Kentucky staff was the concern about being separated from children and other vulnerable family members.

TABLE 1.4. CLIENT BARRIERS TO ENTERING SUD PROGRAMS

% With Rating 4-7*	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Program and resource barriers	**82.6%**	**52.3%**	**81.1%**	**80.0%**	**77.7%**
Program barriers	70.7%	46.9%	75.5%	77.1%	67.6%
Difficulty making time for treatment due to limited flexibility of appointments *(e.g., work conflicts)*	49.3%	26.2%	43.4%	48.6%	45.3%
Program or treatment is too far away from where clients live	40.5%	12.3%	49.1%	57.1%	37.3%
Criteria needed to enter in program too strict *(e.g., Withdrawal point, clean urine sample)*	38.9%	10.8%	45.3%	42.9%	35.1%
Ability to see a therapist or counselor quickly	30.9%	20.0%	15.1%	37.1%	28.5%
Difficulty making and getting an appointment	30.6%	12.3%	30.2%	31.4%	27.7%
Paperwork burden on clients	31.9%	11.5%	20.8%	25.7%	27.7%
Resource barriers	75.9%	30.0%	66.0%	74.3%	68.1%
Access to safe and affordable housing	63.7%	17.7%	52.8%	60.0%	55.7%
Transportation to treatment	52.2%	16.9%	54.7%	60.0%	47.2%
Difficulty meeting basic needs *(e.g., food, clothing)*	48.9%	13.1%	28.3%	28.6%	41.2%
Concern for personal safety or not feeling safe	28.0%	10.8%	22.6%	17.1%	24.5%
Accessibility barriers	**68.0%**	**34.6%**	**69.8%**	**62.9%**	**62.7%**
Cost of treatment	35.0%	16.2%	32.1%	74.3%	68.5%
Limits imposed by insurance	43.6%	16.9%	30.2%	34.3%	38.2%
Lack of insurance coverage	43.6%	14.6%	35.8%	31.4%	38.1%
Bed availability	38.5%	16.9%	50.9%	25.7%	35.4%
Waitlist for appointments	31.9%	14.6%	39.6%	28.6%	29.5%
Program quality barriers	**54.6%**	**31.5%**	**60.4%**	**51.4%**	**51.3%**
Concern about judgment from staff	27.3%	9.2%	28.3%	17.1%	24.1%
Program staff are not knowledgeable	26.0%	13.1%	26.4%	20.0%	23.8%
Quality of peer support workers/led services *(e.g., lack of supervision, lack of knowledge or training of peer support workers, limited time or availability of peer support workers)*	24.1%	10.8%	24.5%	37.1%	22.6%
Program staff in some programs are not professional	20.5%	13.8%	17.0%	25.7%	19.4%
Not enough structure in some programs	20.2%	4.6%	26.4%	14.3%	17.9%
Lack of diversity	16.9%	6.9%	17.0%	11.4%	15.1%
Exploitation of clients or other organizational issues that make clients feel they are not the highest concern	14.8%	6.9%	22.6%	22.9%	14.4%
Lack of evidence-based treatment options offered to clients	12.2%	5.4%	18.9%	20.0%	11.9%
Lack of personal boundaries between clients and staff	11.4%	9.2%	15.1%	8.6%	11.2%
Client-to-client harassment	9.3%	7.7%	11.3%	17.1%	9.5%
Staff harassment towards clients	6.3%	7.7%	7.5%	11.4%	6.8%

TABLE 1.4. CLIENT BARRIERS TO ENTERING SUD PROGRAMS (CONT.)

% With Rating 4-7*	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Adaptability barriers	**62.0%**	**61.5%**	**50.9%**	**82.9%**	**62.1%**
Clients having severe mental health problems	44.2%	43.8%	41.5%	77.1%	45.4%
Having a physical disability	31.4%	29.2%	28.3%	57.1%	31.9%
Being on medication for chronic mental or physical health problems	31.7%	27.7%	26.4%	51.4%	31.6%
Difficulty finding specialized treatment for marginalized groups	29.8%	12.3%	30.2%	48.6%	27.9%
Lack of options other than AA/NA model	29.4%	14.6%	30.2%	42.9%	27.7%
Having learning disability	29.6%	16.2%	26.4%	31.4%	27.4%
Lack of harm reduction options in SUD programs	27.3%	18.5%	24.5%	54.3%	26.9%
Lack of trauma-informed or client-centered care	22.1%	13.1%	22.6%	42.9%	21.6%
Person-treatment mismatch	23.4%	8.5%	22.6%	31.4%	21.4%
Personal barriers	**88.3%**	**81.5%**	**90.6%**	**94.3%**	**87.6%**
Concerns about separation from children or others the client has primary care for	65.7%	63.8%	66.0%	65.7%	65.4%
Embarrassment or shame	63.1%	34.6%	52.8%	51.4%	57.5%
Lack of motivation or interest	59.7%	43.8%	56.6%	65.7%	57.3%
Some clients in some programs are not serious *(e.g., they are mandated to be there or only there for the shelter part of some programs not the recovery part)*	60.2%	40.0%	49.1%	54.3%	56.1%
Lack of family or other support for recovery	57.4%	33.8%	49.1%	42.9%	52.7%
Stigma	58.0%	22.3%	45.3%	27.1%	51.6%
Concerns about separation from or care for pets while in treatment	45.0%	30.8%	32.1%	42.9%	41.9%
Incarceration	46.7%	24.6%	34.0%	25.7%	41.5%
Legal issues	41.3%	19.2%	30.2%	34.3%	36.9%

*Rating scale: 0 = Not at all a barrier; 7 = A significant barrier

Client Barriers to Staying in SUD Programs

Similar to barriers to program entry, respondents were asked how significant the barriers were for SUD clients to staying in a program on a scale ranging from 0-Not at all a barrier to 7-A significant barrier. Scores of 4 – 7 for a specific item were operationalized as a "significant barrier."

For barriers to SUD program engagement (Table 1.5), the factor structure also showed six factors initially but after examining the scree plot and the variance for each factor, the sixth factor accounted for less than 2% of the variance. A five-factor solution was then examined. The Kaiser-Meyer-Olkin measure of sampling adequacy was .964 and the Bartlett's test of sphericity was significant ($p<.001$) and accounts for 61.6% of the variance

(Williams et al., 2012). Table 1.6 shows the results of barriers to staying in a SUD program with examples of the highest rated barriers within each category. The factors identified for staying in a SUD program varied somewhat from the factors identified for entering SUD program. Specifically, three of the five factors for barriers to program engagement were conceptualized the same as the factors identified for barriers to program entry; however, there were some differences in terms of which items loaded onto which factor for these four factors: program quality concerns (11 items, r = .933), accessibility barriers (3 items, r = .822), adaptability barriers (10 items, r = .925). The first and fifth factors for barriers to program engagement were conceptualized somewhat differently from the program entry barriers: program, resource and personal barriers (15 items, r = .932) and support barriers (4 items, r = .774).

The factors identified for staying in a SUD program varied somewhat from the factors identified for entering SUD program.

The program, resource, and personal barriers factor was further divided into program barriers (7 items, r = .861), resource barriers (4 items, r =.857), and personal barriers (4 items, r =.871) separately. Average ratings are presented in Table 1.5.

For program engagement, lack of support barriers had the highest average rating, then adaptability and accessibility factors were next, then program, resource, and personal barriers. Similar to the results of barrier ratings for program entry, program quality barriers had the lowest average rating.

Similar to the patterns across programs for barriers to SUD program entry, Recovery Kentucky staff had the lowest average ratings for each factor. CMHCs had the highest average, compared to the other three programs, for program, resource, and personal barriers and DOC providers had the highest average for adaptability barriers.

TABLE 1.5. AVERAGE RATINGS FOR FACTORS OF CLIENT BARRIERS TO STAYING IN SUD PROGRAMS

Average Ratings for Factors (0-7)	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Program, resource, and personal barriers	2.9	1.6	2.6	2.6	2.4
Program barriers	2.6	1.5	2.3	2.3	2.2
Resource barriers	3.2	1.4	2.7	3.0	2.6
Personal barriers	3.3	2.0	2.9	2.8	2.7
Accessibility barriers	3.6	1.5	3.3	2.4	2.7
Program quality barriers	1.8	1.3	2.0	2.0	1.8
Adaptability barriers	2.7	2.2	2.7	3.6	2.8
Support barriers	3.9	3.2	3.8	3.7	3.7

About four-fifths (82.0%) of the respondents rated at least one program, resource, or personal barrier as a significant barrier (between 4 and 7; see Table 1.6). Similarly, about four-fifths (82.8%) of the respondents rated at least one of the support barriers as a

significant barrier, suggesting that support for recovery and for program participation is crucial to client engagement in the program. Three-quarters of respondents rated at least one of the adaptability barriers as a significant barrier and two-thirds of respondents rated at least one of the accessibility barriers as a significant barrier. Similar to program entry, program quality barriers had the fewest participants (50.9%) who rated at least one of the barriers as a significant barrier.

Over half of the respondents rated access to safe and affordable housing, clients having mental health problems, concerns about separation from children or other vulnerable family members, some clients not taking the program seriously, and lack of family or other support for recovery as a significant barrier.

On most of the specific barriers, fewer staff from Recovery Kentucky rated on the high end of the scale compared to the other three programs. The barriers most frequently rated as significant barriers for Recovery Kentucky staff included concerns about being separated from children and other family members, clients having severe mental health problems, lack of motivation, and some clients not taking the program seriously.

Over half of CMHC staff rated access to safe and affordable housing, time conflicts, transportation to treatment, limits posed by insurance, lack of motivation, concerns about separation from children and other vulnerable family members, clients not taking the program seriously, and lack of family or other support for recovery as significant barriers. Over half of prenatal program staff rated access to safe and affordable housing, and client motivation as significant barriers. Over half of DOC staff rated time conflicts, transportation to treatment, lack of motivation, clients having severe mental health problems, clients having a physical disability, clients being on medications for chronic mental or physical health problems, concerns about separation from children or other vulnerable family members, some clients not taking the program seriously, and lack of harm reduction options as significant barriers.

TABLE 1.6. CLIENT BARRIERS TO STAYING IN SUD PROGRAMS

% With Rating 4-7*	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Program, resource, and personal barriers	**86.8%**	**58.5%**	**81.1%**	**85.7%**	**82.0%**
Program barriers	71.2%	45.4%	71.7%	77.1%	67.5%
Difficulty making time for treatment due to limited flexibility of appointments *(e.g., work conflicts)*	51.7%	23.1%	47.2%	57.1%	47.2%
Criteria needed to stay in program too strict *(e.g., Withdrawal point, clean urine sample)*	38.2%	19.2%	34.0%	31.4%	34.7%
Program or treatment is too far away from where clients live	34.8%	10.8%	45.3%	42.9%	32.1%
Bed availability	27.0%	13.8%	15.1%	14.3%	23.6%
Ability to see a therapist or counselor quickly	24.4%	16.9%	15.1%	25.7%	22.7%
Scheduling an appointment while in SUD programs	24.9%	9.2%	15.1%	14.3%	21.4%
Paperwork burden on clients	22.4%	10.8%	13.2%	17.1%	19.8%

TABLE 1.6. CLIENT BARRIERS TO STAYING IN SUD PROGRAMS (CONT.)

% With Rating 4-7*	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Resource barriers	72.0%	27.7%	62.3%	74.3%	64.6%
Access to safe and affordable housing	62.6%	22.3%	52.8%	24.3%	55.3%
Transportation to treatment	45.9%	14.6%	37.7%	62.9%	41.2%
Difficulty meeting basic needs *(e.g., food, clothing)*	43.3%	10.0%	20.8%	28.6%	36.0%
Concern for personal safety or not feeling safe	24.1%	7.7%	15.1%	20.0%	20.8%
Personal barriers	68.9%	36.9%	58.5%	62.9%	63.0%
Embarrassment or shame	50.2%	25.4%	35.8%	31.4%	44.7%
Stigma	49.4%	22.3%	37.7%	42.9%	44.2%
Legal issues	42.3%	20.0%	30.2%	28.6%	37.5%
Incarceration	43.3%	15.4%	26.4%	25.7%	37.1%
Accessibility Barriers	**71.5%**	**34.6%**	**62.3%**	**51.4%**	**64.3%**
Limits imposed by insurance	53.8%	16.2%	45.3%	37.1%	46.7%
Cost of treatment	48.1%	22.3%	45.3%	37.1%	43.5%
Lack of insurance coverage	49.3%	16.2%	47.2%	25.7%	43.0%
Program quality barriers	**52.8%**	**37.7%**	**58.5%**	**54.3%**	**50.9%**
Program staff are not knowledgeable	26.2%	15.4%	30.2%	34.3%	25.1%
Quality of peer support workers/led services *(e.g., lack of supervision, lack of knowledge or training of peer support workers, limited time or availability of peer support workers)*	26.0%	15.4%	26.4%	31.4%	24.6%
Program staff in some programs are not professional	24.6%	20.0%	22.6%	34.3%	24.1%
Not enough structure in some programs	23.7%	13.8%	28.3%	28.6%	22.7%
Concern about judgment from staff	21.5%	10.0%	22.6%	11.4%	19.3%
Exploitation of clients or other organizational issues that make clients feel they are not the highest concern	18.4%	12.3%	24.5%	37.1%	18.6%
Lack of diversity	17.7%	7.7%	20.8%	14.3%	16.2%
Lack of evidence-based treatment options offered to clients	16.3%	9.2%	18.9%	25.7%	15.7%
Lack of personal boundaries between clients and staff	15.4%	12.3%	22.6%	14.3%	15.4%
Client-to-client harassment	13.3%	12.3%	22.6%	28.6%	14.4%
Staff harassment towards clients	8.5%	7.7%	15.1%	14.3%	9.0%
Adaptability barriers	**74.1%**	**69.2%**	**81.1%**	**91.4%**	**74.5%**
Lack of motivation or interest	61.6%	46.2%	62.3%	71.4%	59.7%
Clients having severe mental health problems	46.3%	47.7%	39.6%	77.1%	47.4%
Having a physical disability	31.9%	30.8%	32.1%	57.1%	32.8%
Being on medication for chronic mental or physical health problems	31.4%	24.6%	22.6%	60.0%	31.0%
Having learning disability	33.8%	18.5%	28.3%	28.6%	30.9%

TABLE 1.6. CLIENT BARRIERS TO STAYING IN SUD PROGRAMS (CONT.)

% With Rating 4-7*	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Difficulty finding specialized treatment for marginalized groups	31.7%	13.1%	30.2%	42.9%	29.2%
Lack of harm reduction options in SUD programs	28.8%	19.2%	26.4%	54.3%	28.2%
Lack of options other than AA/NA model	28.8%	13.8%	30.2%	45.7%	27.3%
Person-treatment mismatch	25.7%	9.2%	26.4%	31.4%	23.4%
Lack of trauma-informed or client-centered care	24.2%	12.3%	22.6%	40.0%	22.9%
Support barriers	**85.0%**	**70.8%**	**84.9%**	**85.7%**	**82.8%**
Concerns about separation from children or others the client has primary care for	65.5%	58.5%	67.9%	60.0%	64.3%
Some clients in some programs are not serious *(e.g., they are mandated to be there or only there for the shelter part of some programs not the recovery part)*	65.2%	45.4%	58.5%	65.7%	61.7%
Lack of family or other support for recovery	62.3%	31.5%	52.8%	42.9%	56.1%
Concerns about separation from or care for pets while in treatment	42.6%	25.4%	26.4%	42.9%	38.9%

*Rating scale: 0 = Not at all a barrier; 7 = A significant barrier

Only 13.7% of respondents indicated there were other barriers for program entry and/or engagement. Because a minority of respondents indicated there were other barriers, differences by program were not examined and results are not displayed in a table.

Among those who mentioned client barriers, 27.2% of respondents mentioned resource barriers. Respondents mentioned housing and income as well as resources such as lack of storage for belongings, no phone or internet, and lack of transitional housing. One respondent summarized client resource barriers with:

- *"Having initial transportation to appointments. Having all documentation to complete initial paperwork, such as a driving license or ID. Obtaining insurance, or securing transportation to attend appointments with community partners to obtain coverage. Sustaining motivation while encountering obstacles during the intake process."*

The next most frequently mentioned barrier, among those who mentioned other barriers, was special needs (17.5%) including LGBTQ+ identity, language and citizenship barriers, religion, dietary restrictions, and age gap issues.

No motivation was mentioned next most frequently (16.7%).

Program approach issues (13.2%) was next and that theme included things like staff resistance to MAT, treatment episode being either too short or too long, religious

focus of programs, lack of harm reduction options, and overcrowding. One respondent summarized this theme with:

- *"Finding a substance abuse center that does not allow medication-assisted treatment for clients that do not wish to be around it; or conversely, clients that are on treatments like Suboxone that have hesitancy in entering a program that is based on the 12 Steps due to community feelings of medication assisted in Narcotics Anonymous groups."*

Insurance restrictions (11.4%) was mentioned as another barrier, even though it was listed as a barrier. There are a host of restrictions that insurance providers may put on clients or the program. For example, one respondent said: [another barrier is] "not accepting clients that are in dire need of assistance and can't get in because they only have Medicare and not Medicaid."

Next was the lack of information (10.5%) that clients have about what resources are out there to support recovery as well as what program types they could choose from, particularly for those with special needs or circumstances. Additionally, this category included the lack of information about the program or what to expect once they enter the program.

The following barriers had 8% or fewer of respondents mention them and include:

- *"Having certain criminal charges or convictions (e.g., sex offender), being involve[d] in DOC or DCBS which dictate client care, or probation officer interference."*
- *"The risk of losing a job if they go to treatment or risk their job due to schedule conflicts between the job and treatment."*
- *"Having a lack of self-confidence to go to a program or for recovery, being afraid of the unknown, or feeling that nobody can relate to them or their situation or being afraid of the unknown."*
- *"Needing detox or having withdrawal symptoms."*
- *"The time it takes to get meaningful help (e.g., time between intake and an appointment, not having a phone)."*
- *"Not enough focus on life skills (e.g., filling out application, proper hygiene), difficulty transitioning to real life, and lack of relapse prevention coping skills."*

Experiences of Client Exploitation in SUD Programs

Just over one-third (34.2%) of respondents indicated they had heard clients talk about exploitation or being treated unfairly (Table 1.7). Many of the experiences described were explicitly stated as occurring in SUD programs other than the one in which the respondent worked. This ranged from just over a quarter (26.2%) of Recovery Kentucky to just over

half of DOC respondents (54.3%).

Those who indicated they had heard about client experiences of exploitation or being treated unfairly were asked to describe some examples. As Table 1.7 shows, clients talking about **unfair treatment** was the most frequently mentioned example across all of the programs. Some examples of this are listed below:

- *“Unfair treatment by staff, staff having favorites, discrimination, judgments, unethical practices.”*
- *“I have had clients say they had been in programs where they felt disrespected and talked down to.”*
- *“[Program staff] going against doctor’s recommendations about which medications a client is allowed to take, using threatening and intimidating tactics [to keep clients from taking the medication] thus retraumatizing them.”*
- *“Humiliating clients such as [making them] wear a toilet seat around their neck for having a potty mouth.”*
- *“One agency discharged people out of the program without providing them with their cell phone, wallet, or medications at time of discharge. Clients are dropped off at a desolate location in a rural area. They had to schedule an appointment to pick up their remaining belongings, but don’t have access to money or phone for at least 24 hours and generally are not from the area.”*

The next most frequently mentioned theme is related to **financial or labor exploitation** including such examples of program staff using donations intended for clients, using client’s government aid, and charging for services they did not receive. Additionally, providers indicated some clients talked about money or other things being stolen from them or that clients had been forced to work for the program for no or minimal pay. Examples of programs putting profits over the client:

- *“Many clients that come to us express barriers from other clinics such as being treated like an outcast, rushed in and out without fulfilling their needs, being thought of us a money/insurance profit instead of a patient. Feeling stigmatized for being an addict and treated less than because of it.”*
- *“Staff made sure that clients had no down time or bonding time with their newborns due to having to be in a structured group or individual activity every hour of the day for billing purposes.”*

Other providers talked about government benefits being taken, being charged excessively for services, and being billed for services they did not receive:

- *“[Clients have talked about how program staff] took their SNAP card, the high cost of room/board but not offering help to get to services leaving clients to do or work anywhere to be able to pay room/board. [Some talked about programs having] substandard living conditions but charging rent.”*

- *"Clients have mentioned that food is bought with money taken from them and sold back to them at a higher price."*

- *"Some halfway houses have been accused of taking excessive rent money without providing enough support/programming."*

- *"Clients have been billed for services they did NOT receive."*

Other providers mentioned labor exploitation:

- *"Clients have described situations where they have been required to work at a SUD program and [they were] told that it was part of their treatment."*

- *"Clients have mentioned that past facilities they have been in forced them and other clients to sell merchandise in parking lots."*

- *"Clients reported that an owner of SUD residential facility also owned a bar and required the clients of the residential center to work at the bar."*

Program quality issues were also mentioned, although much less so for Recovery Kentucky staff. This theme included information such as overcrowding, lack of services that clients need or want, or issues with the facility or how the program was run as the following examples mention:

- *"Clients being placed in services that are not appropriate for the level of treatment they needed."*

- *"Poor facility conditions (e.g., bed bugs, roaches)."*

Clients being made to feel as if they are just a number, not cared for, not listened to, or only there so the agency can make money. For example:

- *"I have heard people say that they didn't always have workers who took their issues seriously, and didn't treat them like people, and it changed how they looked at programs from that point on."*

- *"Only seen as a number; they don't care if you use as long as you show up and dose."*

- *"Clients often speak about prior experiences where they felt like they were just there for insurance money and that staff did not really care about the client, only money."*

- *"Staff were aware that other clients in the house were still using and did not care because it became all about the money, not helping the client."*

- *"Patients often share experiences with other facilities where they are 'just a number' or 'just a warm body' and are not treated as individuals with needs."*

- *"At a previous recovery center I worked for, clients frequently talked about not receiving services that their insurance was being billed for and feeling like the facility receiving money was far more important than their well-being."*

Several respondents mentioned **boundary issues or sexual exploitation**. Examples of sexual exploitation mentioned included:

- *"Treatment staff offering program benefits for sexual favors."*

- *"The person stated that there were clients who were being taken advantage of from staff by the staff offering them drugs to sleep with them."*

Although only a few mentioned **MOUD/MAT-related exploitation**, this theme included feeling coerced into or given inappropriate dosage levels. For example:

- *"Feeling judged or pushed through just to be given meds, given a higher dose of MAT meds than needed to keep them coming back."*

- *"Most cash-based MAT programs are over prescribing and telling their patients 'You will need this prescription for the rest of your life' while giving no counseling or recovery education while they are being seen at the clinic."*

TABLE 1.7. EXPLOITATION EXPERIENCES OF CLIENTS IN SUD PROGRAMS

(%) Yes	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Have heard clients talk about being exploited or not being treatment well while in a SUD program or that the program was corrupt	34.6%	26.2%	35.8%	54.3%	34.2%
% Mentioned Theme	n = 213	n = 34	n = 19	n = 19	n = 285
Unfair treatment	41.3%	32.4%	47.4%	31.6%	40.0%
Financial or labor exploitation	12.7%	11.8%	36.8%	26.3%	15.1%
Program quality issues	14.6%	2.9%	26.3%	5.3%	13.3%
Client is just a number	10.3%	8.8%	5.3%	0.0%	9.1%
Substance use	8.9%	8.8%	0.0%	15.0%	8.8%
Boundary issues	5.2%	2.9%	15.8%	0.0%	5.3%
Sexual exploitation	5.2%	0.0%	5.3%	5.3%	4.6%
MOUD/MAT-related exploitation	2.8%	0.0%	0.0%	0.0%	2.1%

Program Restriction Barriers for Engaging Clients in SUD Programs

Over a quarter (28.5%) of respondents across programs indicated there were program restrictions that impact SUD program engagement. The lowest agreement was for Recovery Kentucky respondents (18.5%) while the highest agreement was for DOC respondents (48.6%).

> *"We have to meet our clients where they are. I don't think we should require them to have to have a certain criterion before they can start a program."*
>
> \- PROVIDER SURVEY PARTICIPANT

When examining specific responses, **sanctions or termination for relapse** was the most frequently mentioned barrier across all of the programs (see Table 1.8). The quotes below, from a few of the respondents, underscore some of the thoughts:

- *"When clients relapse, they are discharged from programs. It is not uncommon for a client to relapse; I feel there should be something else put in place for times when this occurs instead of discharging."*
- *"Some clients are kicked out of programs because of relapses and sent back to jail. I feel like this is a problem because I believe in second chances, and I think it can discourage clients from pursuing further treatment."*
- *"Some other programs discharge clients for testing positive on screens or relapse. Relapse is part of recovery and ending services tends to make the person want to continue using. It is important to provide more support or change the way treatment is done to lessen the risk of relapse."*

This may be an issue particularly for court-involved clients:

- *"Our clients are automatically discharged from the program if they have a negative drug screen; however, this rule is largely dictated by our relationship with many referral sources, including district, circuit, federal and drug courts."*
- *"The DOC is typically much more lenient when clients miss my IOP group classes, and they are much less lenient when clients relapse on illegal substances. The DOC takes an abstinence only approach and will discharge quickly when a relapse happens. I cannot provide services to clients who relapse when they become incarcerated. This means I cannot help them when they relapse, and I do see it as somewhat of a problem since substances are often available in prison/jail and I do not know whether their treatment is continued while they are in prison/jail."*

Others mentioned that sanctions or termination for relapse were applied to only some of the clients and that creates a problem.

- *"I only think it's a problem because all clients are not being treated the same. One client may relapse and get a second chance but another one will get kicked out the program.*

It needs to be fair all across the board. We set the clients up for failure by just throwing them back out instead of getting them in talking to them and seeing the reason for the relapse."

The next most frequently mentioned program restriction was **programs requiring negative drug screens before entry** (12.2%) across all of the programs. Several respondents summarized this theme with:

- *"I've heard of programs that require negative drug screens upon intake. I feel that this is a significant barrier to entering treatment because not everyone has the strength to get clean BEFORE coming to treatment."*
- *"Requiring sober drug tests prior to treatment does make sense for certain substances, but for something like marijuana which can take 30 days to leave your system, this can mean that a client has to wait a month before they can get treatment. Marijuana is also legal in certain states and can be used for harm reduction. Demanding complete abstinence can make it so clients never get any form of treatment because they can't meet program requirements."*
- *"Some of the criteria are that the clients have to have negative drug screens and if the clients relapses, then they are kicked out of the program. I feel like this tells the clients that if they relapse one time that they are hopeless and cannot receive the help that they truly need."*

The **program approach** was the next most frequently mentioned barrier and was higher for Recovery Kentucky staff than for staff from the other programs. This barrier included program philosophy (e.g., specific treatment style that doesn't suit client such as exclusively AA/NA or religious approach; not allowing harm reduction; needing more one-on-one time) and rules or procedures such as wait times for SUD appointment, not being able to move or switch rooms due to personality clashes, the program having rigid expectations, and clients not having choices.

> ***"Any amount of wait time for a client with SUD is a huge barrier. I think you have to get their attention the moment they humble themselves to ask for help!"***
>
> \- PROVIDER SURVEY PARTICIPANT

Some of the respondents mentioned the theme of **programs requiring clients to have positive drug screens before entering**.

Another theme was the **lack of program flexibility**, which is similar to program approach theme. One respondent summarized this theme with:

- *"[There are] specific days/times for outpatient treatment, and [requiring] too many days can be a burden and very difficult or impossible to manage when using substances. It is difficult to stop use of substances in an outpatient setting, living in the same environment where use occurred, with little safety from triggers."*

Clients having **co-occurring needs** and **program or paperwork burden** were also both mentioned here. With regard to clients having co-occurring needs, respondents expressed concerns about mental health problems not being addressed or clients not being able to take prescriptions during treatment. With regard to paperwork burden respondents mentioned paperwork, screenings, insurance burdens, not having an ID or requiring several appointments before treatment can start.

TABLE 1.8. PROGRAM RESTRICTION BARRIERS FOR CLIENT ENGAGEMENT IN SUD PROGRAMS

% Yes	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Programs (yours or others) require certain things from clients that you believe reduce client motivation or their ability to enter and/or continue in treatment (%)...	29.1%	18.5%	32.1%	48.6%	28.5%
% Mentioned Theme	n = 179	n = 24	n = 17	n = 17	n = 237
Sanctions or termination for relapse	45.3%	33.3%	47.1%	64.7%	45.6%
Programs requiring negative drug screens before entry	10.6%	25.0%	11.8%	11.8%	12.2%
Program approach.....................................	4.7%	16.6%	5.9%	5.9%	7.6%
Programs requiring positive drug screens before entry..	7.2%	4.2%	11.8%	5.9%	7.2%
Lack of program flexibility	5.6%	0.0%	0.0%	0.0%	4.2%
Co-occurring needs....................................	3.4%	4.2%	0.0%	11.8%	3.8%
Program or paperwork burden..................	2.8%	8.3%	0.0%	0.0%	3.0%

Summary of client barriers to SUD program engagement

Although respondents indicated that individuals with co-occurring mental illness, younger adults (18-24 years old), women, individuals who are homeless, and individuals who do not have insurance have the most difficulty engaging in SUD programs, they were not the same groups that respondents thought they or their organization could better serve. Respondents thought that they or their organization could better serve non-English speaking clients, adolescents (11-17 years old), persons on active duty in the military and their families, veterans, seniors/older adults (55+), pregnant and post-partum women, LGBTQ +, racial/ethnic minorities, and clients with co-occurring vulnerabilities other than mental health (e.g., physical, mental, developmental, or learning disabilities, chronic pain).

When considering specific barriers to program entry, personal barriers (e.g., concerns about being separated from children, embarrassment, and motivation) were the highest rated overall, on average. The next highest rated were program barriers as well as adaptability barriers or lack of adaptation to client needs (e.g., clients having severe mental health problems, physical disability or chronic health problems). Closely following

that were accessibility barriers. Program quality barriers were the lowest rated overall (e.g., concerns about judgment from staff, knowledge of program staff, quality of peer support workers or led services).

However, the significant barriers for staying in treatment were somewhat different than the significant barriers for entering programs, About four-fifths (82.0%) of the respondents rated at least one program, resource, or personal barrier as a significant barrier (between 4 and 7). Similarly, about four-fifths (82.8%) of the respondents rated at least one of the support barriers as a significant barrier, suggesting that support for recovery and for program participation is crucial to client engagement in the program. Three-quarters of respondents rated at least one of the adaptability barriers as a significant barrier and two-thirds of respondents rated at least one of the accessibility barriers as a significant barrier. Similar to program entry, program quality barriers had the fewest participants (50.9%) who rated at least one of the barriers as a significant barrier.

About one-third of respondents reported they had heard about clients being exploited or not treated well in SUD programs including being treated unfairly or differently from other clients, financial or labor exploitation, and program quality issues.

Over one-quarter of respondents indicated they believed SUD programs had restrictions that impact SUD engagement including termination or sanctions for relapse (even though relapse is part of recovery), requiring a negative or a positive drug screen for entry, program approach, and lack of flexibility of the program to meet client needs.

Section 2. Challenges to Working with SUD Clients

In this section results are shown for staff perceptions of: (a) the most challenging factors in working with SUD clients in the past year, (b) how clients most frequently leave SUD programs, (c) benefits and concerns with having peer support workers work with SUD clients, and (d) benefits and concerns of employing former clients in SUD programs.

The Most Challenging Factors in Working with Sud Clients in the Past Year

Respondents were asked to identify the three most challenging things in working with clients who have SUDs in the past year. Overall, almost all of respondents mentioned at least one personal barrier as a challenge to working with SUD clients (Table 2.1). Specifically, more than half of respondents indicated that client motivation (62.5%) was a challenge in the past year while close to half (46.8%) indicated that client relapse was a challenge. Also, over one-third of respondents indicated that clients having limited personal resources (37.6%) and co-occurring disorders (36.4%) were challenges. There was not much variation by program although relapse was rated lower while co-occurring disorders were rated higher as a challenge by DOC staff than the other programs.

Almost three-quarters of respondents (71.5%) identified any of the systemic barriers as challenges in working with SUD clients in the past year. Specifically, respondents mentioned limited community resources (31.7%), limits due to insurance (25.8%), and COVID causing ongoing problems were challenges to working with clients. COVID causing ongoing problems was mentioned by about one-third (32.3%) of Recovery Kentucky staff, which was a higher percentage than for staff from the other types of programs.

Agency level barriers (16.4%) were infrequently identified as challenges in working with SUD clients compared to personal and systemic barriers. Agency level barriers included treatment access issues, clinicians' lack of skills, or lack of agency or leadership support in organizational issues.

Although the list of challenges assessed in the survey may not have included all of the challenges staff face in working with SUD clients, only 3.2% overall indicated there were challenges other than what was listed. Of those respondents who listed other challenges, limited client resources such as housing, finances, and transportation were most mentioned (although this was also included in the list of challenges provided to respondents). A few mentioned challenges with mandating agencies interfering or arresting clients for trivial reasons, client deaths, and client aggression as challenges.

TABLE 2.1. THE MOST CHALLENGING FACTORS IN WORKING WITH SUD CLIENTS IN THE PAST YEAR

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Personal barriers	**96.1%**	**96.2%**	**98.1%**	**94.3%**	**96.2%**
Client motivation	62.3%	67.7%	69.8%	37.1%	62.5%
Relapse	45.4%	58.5%	50.9%	22.9%	46.8%
Clients have limited personal resources	41.1%	21.5%	32.1%	42.9%	37.6%
Co-occurring disorders	33.7%	48.5%	28.3%	51.4%	36.4%
Systemic barriers	**71.9%**	**66.9%**	**71.7%**	**82.9%**	**71.5%**
Limited community resources	35.0%	14.6%	34.0%	34.3%	31.7%
Limits put on treatment by insurance	28.6%	11.5%	32.1%	20.0%	25.8%
COVID has caused ongoing problems	14.5%	32.3%	9.4%	22.9%	17.3%
Limits put on treatment by the criminal justice system	13.0%	22.3%	15.1%	37.1%	15.6%
Treatment coordination issues	4.1%	5.4%	5.7%	2.9%	4.3%
Cannot get clients connected to physicians for medication for opioid use disorders	0.7%	3.8%	0.0%	0.0%	1.1%
Agency level barriers	**17.4%**	**11.5%**	**15.1%**	**20.0%**	**16.4%**
Treatment access issues	7.6%	1.5%	5.7%	8.6%	6.6%
Clinicians lack skills for substance abuse treatment	5.7%	6.2%	7.5%	8.6%	6.0%
Lack of agency/leadership support or other organization issues	5.5%	3.8%	1.9%	5.7%	5.0%

How Clients Most Frequently Leave SUD Programs

Table 2.2 shows that the majority of respondents (71.8%), regardless of program, reported that clients graduate or there is mutual agreement that they are ready to leave treatment frequently or very frequently. Dropping out of treatment was the next most frequently mentioned way clients frequently or very frequently leave treatment (42.4%) and less than one-third (29.9%) indicated clients frequently or very frequently miss too many appointments and are discharged. There were not many differences by programs, except fewer prenatal program staff indicated that clients just drop out of treatment compared to the other three programs.

TABLE 2.2. HOW CLIENTS MOST FREQUENTLY LEAVE SUD PROGRAMS

Exit frequently or very frequently (%)	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Clients graduate OR there is mutual agreement that they are ready to leave treatment	69.9%	79.2%	83.0%	60.0%	71.8%
Clients just drop out of treatment or stop showing up	42.0%	46.9%	26.4%	57.1%	42.4%
Clients tell clinicians they are leaving treatment before they are ready	29.6%	42.3%	32.1%	28.6%	31.7%
Clients fail to keep appointments too many times and are discharged	33.0%	16.9%	15.1%	45.7%	29.9%
Clients go to jail/prison	17.7%	11.5%	3.8%	31.4%	16.4%
Clients are not allowed by program to continue for reasons other than missed appointments	12.7%	13.1%	9.4%	25.7%	13.1%
Clients transfer to other providers or services	9.8%	9.2%	5.7%	11.4%	9.5%
Clients move away, which disrupts their treatment	7.8%	6.9%	1.9%	5.7%	7.2%

Benefits and Concerns with Having Peer Support Workers in SUD Programs

The majority of respondents indicated they recommend peer support workers (93.4%) to work with SUD clients (Table 2.3). Respondents were asked to identify three benefits and three concerns with peer support workers working with SUD clients.

Starting with the benefits, three themes were most frequently mentioned: peer support workers having shared experience with clients, they serve as a positive role model for current clients, and they build rapport more easily with current clients. As noted in the following responses, many respondents thought a significant benefit of peer support workers is **having shared experiences** with clients (62.9%) they have with current clients, which can be powerful in helping them on their recovery journey. For example:

> *"Having someone with relatable experience on their treatment team serves as a beacon of hope to those in recovery. "*
>
> - PROVIDER SURVEY PARTICIPANT

- *"They suffer from the same disease, they are not better than the clients, they just have a little more sobriety."*

Closely related, peer support workers **serve as role models** for current clients (53.8%) including giving hope, giving advice and providing a positive example of what the future of recovery can be. For example:

- *"Peer support specialists [provide] a positive example for the client; to see someone who was once in a similar place in life to them and they have been able to turn their life around in a positive manner."*
- *"Peer support mentors can be a positive figure in the client's life and show them recovery is possible."*
- *"Peer support workers can help clients in the program due to their knowledge of the program and services they can provide (e.g., they are knowledgeable about the experience, life lessons, the life of an addict)."*
- *"A positive aspect of SUD clients working with peer supports is the support and encouragement that can be given to the client as they try to recover."*
- *"[A benefit is] having someone on their treatment team that can help navigate legal systems, insurance deficiencies and other issues, because they have done so themselves."*
- *"Peer support specialists can be a source of recovery information that someone who has never struggled with substance use might not know."*
- *"Clients are able to see a first-hand account of someone who has changed their life for the better - clients can see that if the peer support specialist can do it, so can they."*
- *"It gives the client hope seeing someone who struggled with addiction, living a different life. If it was possible for the peer support workers, it is possible for the client."*

"Providing hope that someone who was once trapped in the life can get out."

\- PROVIDER SURVEY PARTICIPANT

Additionally, the ability to **more easily build rapport with clients** than other program staff due to their shared experiences and being a positive role model was also frequently mentioned (50.5%). The following are examples of what respondents said about this:

- *"Open-mindedness provided from the peer. The peer doesn't judge the client and so the client will feel more comfortable talking to a peer instead of someone else, because they trust them and feel safe talking to them."*
- *"Clients feel it's easier to open up to peer support workers who have had some of the same experiences."*
- *"Talking with someone who has been in their shoes before makes them feel less judged than someone who has never experienced addiction."*
- *"They may not see them as an authority figure, whereas institution staff, even clinical, can be viewed as such."*

- *"Giving a client a social support. Often times when SUD clients are working toward or new to recovery, they have cut ties with old associates as to prevent relapse, but they aren't associating with people that they were friends with prior to being in active addiction (stigma, those people no longer trust client, don't want to be "guilty by association") so the peer support workers gives client a new friend/social support. It can be encouraging to clients to have someone with them to do activities with while sober."*

> ***"They have a go-to person to guide them through one of the most, if not THE most, challenging moments of their life."***
>
> \- PROVIDER SURVEY PARTICIPANT

- *"I think clients can truly benefit from hearing from someone who has been where they have been, I think it can carry more weight than someone working with them who has only has book learning on the subject."*

Less frequently mentioned was that peer support workers can also **help current clients with relapse prevention** by holding them accountable with substance use as well as with program compliance and helping them stay engaged in the program (14.6%).

Less frequently mentioned was the help that peer support workers provide to the program overall and to other program staff by **providing help to clients** (6.8%). Mentioned within this theme is that peer support workers can provide outreach and stay in touch when clients transition out of the program. Also, they can provide input into the program policies from an informed position. For example:

- *"They are more available, accessible and can spend more time with clients than therapist and case workers."*

- *"Peer supports do an amazing job at advocating on behalf of clients."*

- *"Can talk with them after they leave the program."*

Very infrequently mentioned was the idea that peer support workers can **help teach clients how to advocate for themselves** and that can help reduce stigma (2.8%).

There were several concerns mentioned with peer support workers as well including boundary issues (37.5%) and relapse risk for the peer support workers (20.0%). More staff from DOC programs mentioned relapse risk (40.0%) than staff from other programs. The following are excerpts of respondents' thoughts about **boundary issues of peer support workers**:

- *"Boundaries: If there aren't boundaries set between the peer and client, that can end up negatively for both parties."*

- *"If the peer support specialist does not clearly define their role, it can cause a client to rely on them for counseling services for mental health issues that they may not necessarily be trained for."*

- *“There is a chance that they could lead each other down a path that is bad for both of them, but I believe the benefits of working with the right peer support workers far outweigh the downsides.”*

- *“Peer support specialists may have difficulty in balancing the relationships that they have with their clients with the relationships that they have with their clinician coworkers. Loyalty may be confusing and/or difficult for them.”*

- *“Boundaries can be hard to keep when the peer support workers develops a lot of empathy for a client that could remind them of themselves when they were in their position.”*

- *“Boundaries could be grayed easily because of clients thinking they are ‘friends’ when the peer support workers is expected to uphold ethics and values as a professional but also mesh on a peer level.”*

Also the following are some thoughts about **relapse risk for peer support workers**:

- *“If the peer support workers aren’t working their program and on their own recovery, there could be a chance of relapse for the peer support workers.”*

- *“Peer support workers may experience own triggers that lead to relapse, and this could be harmful to the client, if they lose their social support, trusted person, etc., it could result in feeling isolated - they could reach back to old associates or have the mindset that the peer support workers used substances, so it must be okay for them to use as well.”*

- *“If a peer was to relapse and the client was working with that peer and looked up to that peer, it can sometimes discourage the client because they thought so highly of the peer and causing the client to lose hope if not careful.”*

- *“If the peer support workers relapses- but that could also be a positive for a client who has recently relapsed, assuring them that it happens and they just need to start where they are and begin their recovery again- A new start date is better than a death date on a head stone.”*

Some respondents mentioned that **peer support workers’ education, knowledge or coping skills** may be limited (17.0%):

- *“Peer support workers may have personal biases regarding certain aspects of treatment (e.g., MAT), and not have the therapeutic training/skills to keep these biases from affecting their interaction with clients.”*

- *“Sometimes peer support specialists are younger and don’t have coping skills you see with those who are older adults.”*

“When peers are newer they may have a more rigid idea of recovery - might be less ‘client-centered’.”

- PROVIDER SURVEY PARTICIPANT

- *"Peer support workers may lack professional knowledge/experience needed to help others."*

Next most frequently mentioned theme was **negative behavior from peer support workers** (16.3%) such as unprofessional behavior, being judgmental or showing favorites, or acting as if they do not care. The following responses are examples:

- *"Sometimes (not all the time) but it does happen where professionalism can become an issue."*
- *"Sometimes peer support workers allow the position to 'go to their heads'."*
- *"[Peer support workers are] not always a good example of recovery."*

Program issues was next most frequently mentioned and this theme included a variety of issues including peer support workers not having enough time to spend with clients (e.g., too many clients per peer support worker), lack of supervision, difficulty finding peer support workers to hire, and other issues. For example:

- *"Peer support specialists can be too busy, not enough help to go around, or conflicts in getting more peer support workers."*
- *"Some agencies forget peer mentors are in recovery too and work them too much, don't provide adequate supervision and have them performing in a role beyond their scope."*
- *"It takes a lot of time to supervise them because many come with their bags still filled with issues and concerns."*
- *"Thinking that the peer support worker is going to solve all of the client's problems."*
- *"Peer support is overused for insurance billing."*
- *"Overemphasis of peer services - occasionally in opposition to clinical and medical services."*
- *"Possible conflicts between peer support workers and clinical staff."*

Some respondents mentioned a concern of **client acceptance of peer support workers** (7.9%).

Less frequently mentioned are the importance of peer support workers having **adequate time in recovery** before taking on the role of a peer support workers and that sometimes **peer support workers may have problematic beliefs** such as there is only one way to recovery or having biases toward certain treatments (e.g., MOUD/MAT).

TABLE 2.3. BENEFITS AND CONCERNS WITH HAVING PEER SUPPORT WORKERS IN SUD PROGRAMS

% Yes	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Recommend peer support workers for SUD programs	96.4%	83.8%	100%	74.3%	93.8%
% Mentioned Theme					
Positive benefits of peer support workers					
Having shared experiences with current clients	64.7%	48.5%	75.5%	65.7%	62.9%
Serving as role models	54.1%	53.8%	47.2%	57.1%	53.8%
More easily building rapport with current clients	50.9%	50.8%	45.3%	51.4%	50.5%
Helping current clients with relapse prevention (e.g., holding clients accountable)	13.5%	16.9%	20.8%	17.1%	14.6%
Providing help to clients	7.2%	5.4%	7.5%	5.7%	6.8%
Teaching clients how to advocate for themselves	2.9%	2.3%	0.0%	5.7%	2.8%
Concerns with peer support workers					
Boundary issues of peer support workers	39.3%	26.9%	37.7%	42.9%	37.5%
Relapse risk for peer support workers	21.8%	9.2%	13.2%	40.0%	20.0%
Peer support workers' education, knowledge or coping skills	17.6%	17.7%	11.3%	14.3%	17.0%
Negative behavior from peer support workers	16.1%	16.2%	18.9%	17.1%	16.3%
Program issues (e.g., limited time for peer support workers to spend with clients, lack of supervision)	8.9%	14.6%	9.4%	14.3%	10.1%
Client acceptance of peer support workers	8.1%	3.8%	15.1%	8.6%	7.9%
Peer support workers must have adequate time in recovery	3.6%	6.9%	7.5%	2.9%	4.3%
Peer support workers may have problematic beliefs (e.g., there is only one way to sobriety, biases)	4.6%	1.5%	1.9%	5.7%	4.0%

Benefits and Concerns of Employing Former Clients in SUD Programs

The majority of respondents from CMHCs, Recovery Kentucky, and prenatal programs indicated their organization hires former clients (overall 71.2% indicated their program hires former clients, Table 2.4). Respondents who indicated their program hires former clients were asked in what capacity former clients were hired as well as about the benefits and concerns (Table 2.4). The following quotes describe their thoughts about hiring former clients.

- *"Almost everyone that works here has been through our program. It is a peer driven program that has been proven to work and continues to work. Employees are no better or no less than our clients and we are able to meet our clients where they are at."*
- *"Most of the staff that work here, including administrative staff, have all gone through this program, or a similar program."*
- *"Clients who have been in the SUD programs make excellent peer supports."*
- *"I work for the same company that [manages the program] I went to, and they gave me the opportunity to be able to give back and help others."*

The largest percentage of respondents indicated their program or agency hires former clients as **peer supports** (38.6%), although former clients can be hired into **roles other than peer support workers** (17.9%) such as drivers, monitors, administrative, kitchen staff, and other roles.

- *"Former clients will start out here as monitors. I personally think this process is very beneficial. I think it makes clients feel relatable. I was hired as a graduate and have been employed here ever since. Seeing former clients as staff, when I was in the program, gave me hope that I could be here one day."*

Respondents mentioned several benefits of hiring former clients, which are similar to some of the benefits mentioned for hiring peer support workers. Mentioned by more than one-fourth of respondents is the benefit of how former clients are **better at building rapport with clients** or how they are better able to relate to and understand the current clients (27.3%). The following quotes highlight why the respondents believe hiring former clients can be beneficial including building rapport, helping with relapse prevention (e.g., being able to hold clients more accountable for relapse as well as program compliance and having credibility in providing support because they have done it themselves):

- *"The benefits are they know how the program works; they can give real life experiences of situations that happened to them in this particular program, etc."*
- *"It helps connect with the clients, someone who has been through the program and easily build rapport because their program is the same."*
- *"It works great with the clients in the program, because they are cared for by others*

that have been through and completed the same program."

- *"Many clients do not want to be guided by someone that has no clue what they are going through."*
- *"As previous clients, they are more aware of various behaviors and situations clients use to go back out and use. They are better at redirecting them."*

"Many times [they] do a better job of holding people accountable. People will [call] them before they call anyone else because they reach them whereas they can't get in to see their therapist. "

- PROVIDER SURVEY PARTICIPANT

The second benefit mentioned is how former clients can **serve as role models and give current clients hope** (16.9%), for example:

- *"Employees who were previous clients are the guiding light post, every day, that recovery is achievable, even when life gets rough living life outside of treatment. It is critical that there is someone who can say 'yes,' me too. I once was where you are and this is how I did it…"*
- *"I believe this is a major benefit to the organization as it allows clients the opportunity to work closely with other addicts who have been in the same exact position as them but overcame and are now living much more successful and fulfilling lives."*

"I believe it motivates other clients to see that this person went through a program, and has now been given a chance to work and have employment where they may think working is not going to ever be an option again. The peer support workers also get the opportunity to give back in the program they are working. "

- PROVIDER SURVEY PARTICIPANT

The next benefit that was mentioned was how former clients **have program knowledge** which can be helpful to current clients (8.4%) as the following examples underscore:

- *"They have been through processes that clients are asked to go through. They know what, how, why, where, when, and who."*
- *"I think this is helpful not only to them but to us as well. They are easier to train as they already have a working knowledge of what goes on day to day around here and you will find they are more loyal employees because they do have a loyalty to this place for helping them to get their lives back on track."*
- *"Benefits are that they know the ins and outs of the program, rules, policies, and criminal mindset."*
- *"I think it's great because they have actually been through this specific program and are more knowledgeable about the rules."*

A few respondents mentioned how hiring former clients provides an **opportunity for personal growth and giving back** (4.0%) for the former clients is also a benefit as noted in the following examples:

- *"This program is a peer driven social model, so it gives them an opportunity to give back and help the clients, learn desk work and paperwork, becoming accustomed to working consistently again, and give them a chance to see if they like working in recovery and staying grounded in their program."*

- *"The benefits are it keeps those who may have little recovery support outside of the environment or area, to continue to be around individuals with significant clean time."*

- *"The benefit to this is that we get them involved with employment to make the transition back to society easier for them financially."*

There were several concerns mentioned about hiring former clients, which were similar to the concerns about having peer support workers work with clients. The most frequently mentioned was concerns about **boundary issues** (11.1%). Some examples of what respondents said are:

- *"But I see also that they develop friendships and personal relationships in the program and when they begin working, they then have to cut that relationship off to strictly professional."*

- *"Clients may have a more difficult time being strict with people they were in the program with."*

- *"One weakness is [former clients] may know some of the [current] clients and clients don't want to listen to people they know personally."*

- *"The only weakness is that the company needs to develop policies and protocols to avoid inappropriate conflicts of interest and dual relationships."*

Additionally, **relapse risk** (6.7%) was also mentioned as noted here:

- *"Tying a person's recovery success to their professional success isn't guaranteed to work and if one of them fails it risks the other."*
- *"The weakness is that sometimes the work can be triggering and leads to relapse in some individuals."*
- *"Some peer support workers relapse and don't report. The clients often find out before the employer, which sends the wrong message."*
- *"I also think that this can be somewhat bad for the client who is now an employee because it may make them feel like they can't reach out if they're struggling to stay sober/having cravings, etc."*

Other factors were also mentioned as concerns including **education and training issues** (3.0%), **employment issues** (2.5%), and that **sometimes programs hire former clients who have not had enough time in recovery** (1.0%). For examples of what respondents meant about education and training issues see the following:

- *"Not all individuals are remotely qualified for what they're doing."*
- *"Some that are in very early recovery are sometimes seen as untrained and unreliable with their information."*
- *"Some staff members aren't accepting newer forms of treatment."*

Examples of employment issues mentioned by respondents are presented here:

- *"Weaknesses include the need for substantial resourcing in order to properly supervise and train a large number. We have approximately 100 active peers."*
- *"I'm concerned that they may not have a safe space to discuss challenges/triggers with their work."*
- *"A weakness I think would be if the former client was not treated as an equal to the rest of the staff."*
- *"The pay for the position is not very high so we struggle to keep people as the cost of living has continued to rise."*

As an example of concerns about length of recovery, one respondent mentioned, "...too much responsibility too quickly for those fresh out of treatment with very little experience clean outside of a controlled environment [could be a problem]."

TABLE 2.4. BENEFITS AND CONCERNS OF EMPLOYING FORMER CLIENTS IN SUD PROGRAMS

% Reported	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Program/organization hires former clients					
No	5.7%	1.5%	5.7%	60.0%	7.3%
Don't know	25.4%	3.1%	20.8%	22.9%	21.5%
Yes	68.9%	95.4%	73.6%	17.1%	71.2%
% Mentioned Theme	n = 424	n = 124	n = 39	n = 6	n = 593
Type of position in which former clients work					
Peer support workers	50.7%	4.0%	20.5%	16.6%	38.6%
Role other than peer support workers	17.0%	20.2%	23.0%	0.0%	17.9%
Benefits of hiring former clients					
Better at building rapport with clients	27.6%	26.6%	25.6%	33.3%	27.3%
Serve as role models and give current clients hope	16.5%	16.9%	33.0%	0.0%	16.9%
Have program knowledge	4.5%	22.6%	7.7%	0.0%	8.4%
Provides former clients with an opportunity for personal growth and giving back	3.5%	6.5%	0.0%	16.6%	4.0%
Concerns with hiring former clients					
Boundary issues	11.3%	7.3%	23.0%	0.0%	11.1%
Relapse risk for former clients	8.3%	4.0%	0.0%	0.0%	6.7%
Education and training issues	2.4%	5.6%	2.6%	0.0%	3.0%
Employment issues *(e.g., supervision needs)*	3.1%	.8%	2.6%	0.0%	2.5%
Sometimes programs hire former clients who have not had enough time in recovery	0.9%	1.6%	0.0%	0.0%	1.0%

Summary of Challenges to Working with SUD Clients

Almost all respondents indicated challenges in working with clients were client level barriers (e.g., motivation and relapse) rather than experiencing systemic or agency-level barriers as challenges in working with SUD clients.

The majority of respondents (71.8%) believed clients graduate (or there is a mutual agreement that clients are ready to leave) frequently or very frequently. Even so, many respondents also indicated clients frequently or very frequently drop out or are unable to proceed with the program because they missed too many appointments or because of their involvement with the criminal justice system.

Almost all of the respondents indicated they recommend peer support workers to work with SUD clients (93.8%) and that there are a variety of benefits in having peer support workers mostly for the current clients but also to help staffing and duties in the program. Closely related, many respondents (71.2%) indicated their program hires former clients and most of them are hired into the peer support workers role. Benefits mentioned for hiring former clients overlap with benefits of peer support workers and include being able to build rapport more easily and serving as role models for current clients.

Concerns about peer support worker employees and hiring former clients also overlap. The most frequently mentioned center around concerns about blurred boundaries, relapse risk or employment being tied to recovery, a lack of training or education, and the need to train and closely supervise them, which requires human resources.

Section 3. Organizational Challenges and Rewards Experienced by Program Staff

This section includes results of respondents' perceptions of; (a) organizational challenges; (b) lingering impacts of COVID; (c) job satisfaction and burnout; and (d) the best aspects of the job.

Organizational Challenges

Respondents were asked about a number of factors that they saw as organizational challenges for their agency (Table 3.1). On average, providers indicated 3.1 organizational challenges were a high or very high degree of a problem. CMHC and DOC staff reported an overall greater number of organizational challenges, on average, compared to prenatal and Recovery Kentucky staff.

More specifically, the most frequently mentioned organizational challenges were staff shortages (48.0%), high caseloads (30.1%), burnout among staff (29.9%), and work characterized as high effort but low rewards (25.1%). Program exploitation/corruption (6.2%) and harassment of clients by other clients or by staff (2.2%-4.3%) were noted very infrequently as concerns.

CMHC staff and DOC staff also frequently mentioned not having enough time for clients compared to the other two programs while Recovery Kentucky staff less frequently mentioned staff caseloads and burnout than staff from the other programs.

TABLE 3.1. ORGANIZATIONAL CHALLENGES

	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Average number of the following items the respondent rated as a problem for their organization to a high or very high degree	3.9	2.4	1.7	4.3	3.1
% rated the item high or very high degree of a problem					
Staff shortages	55.6%	22.3%	32.1%	34.3%	48.0%
Staff caseloads are too high	36.6%	8.5%	7.5%	31.4%	30.1%
Burnout among staff	34.5%	13.8%	13.2%	34.3%	29.9%
The job is high effort *(e.g., busy, exhausting)* but reward is low *(e.g., low pay, title does not reflect job duties)*	26.3%	22.3%	11.3%	34.3%	25.1%
There are limited opportunities for advancement	23.6%	25.4%	15.1%	28.6%	23.5%
Not enough time for clients	27.0%	6.9%	3.8%	37.1%	22.8%
There is limited transparency about decision making	23.1%	15.4%	9.4%	20.0%	20.9%

TABLE 3.1. ORGANIZATIONAL CHALLENGES (CONT.)

	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
The job is demanding but staff have low control over decision making	20.2%	8.5%	5.7%	14.3%	17.2%
Other location problems *(e.g., not enough space, too much space, too far from other services)*	18.7%	7.7%	7.5%	28.6%	16.7%
Lack of funding	15.6%	20.8%	5.7%	20.0%	16.0%
Decisions are not made fairly	14.3%	11.5%	7.5%	17.1%	13.6%
Lack of support for staff from supervisors or higher ups	13.2%	7.7%	9.4%	11.4%	12.0%
There is little flexibility with hours or scheduling or in other ways important to staff	12.4%	9.2%	5.7%	14.3%	11.5%
The program is located in areas of high crime and drug dealing	9.6%	14.6%	9.4%	8.6%	10.3%
Lack of coordination with other community organizations	10.9%	4.6%	1.9%	34.3%	10.3%
% Mentioned less frequently overall					
The organization does not treat staff very well	10.2%	5.4%	3.8%	17.1%	9.4%
There is limited or no teamwork to staff complex cases	8.0%	6.2%	3.8%	8.6%	7.4%
Lack of clinical supervision	7.0%	6.9%	3.8%	8.6%	6.8%
Agency/organization corruption or client exploitation	7.0%	4.6%	1.9%	5.7%	6.2%
Time off is difficult to get approved *(e.g., vacation, sick time)*	5.2%	3.8%	7.5%	0.0%	4.9%
Bullying/harassment of clients by staff or by other clients	3.9%	3.8%	3.8%	14.3%	4.3%
The organization does not treat clients very well	3.7%	3.8%	1.9%	2.9%	3.6%
Sexual harassment by staff or by other clients	2.0%	2.3%	1.9%	5.7%	2.2%

Lingering Impacts of COVID

Over half of respondents indicated there were lingering impacts from COVID (58.3%) while the other 41.1% indicated they did not think there were lingering impacts from COVID. Table 3.2 shows the results in the order of frequency respondents mentioned each theme.

The first theme regarding the lingering impacts from COVID was that there were increased **Zoom or telehealth meetings and appointments** (29.6%).

The next most frequently mentioned theme, overall, was **decreased client attendance and engagement**, which included lower attendance in person and fewer referrals of

clients to the programs (23.5%). A higher percentage of staff from Recovery Kentucky programs said that lower client attendance and engagement was a lingering impact from COVID (42.2%) compared to staff from the other programs. See examples of respondent thoughts on this theme:

- *"Changes in motivation (e.g., the lack of or decreased motivation)."*
- *"Clients or staff not wanting to meet in person, reduction in in-person meetings/personal contact."*
- *"Quantity of referrals of clients being sent to the program or 'lack of referrals' in general (e.g., Referrals down, DOC referrals)."*

Ongoing COVID protocols was the next most frequently mentioned theme (15.6%), which included changes to try to prevent the spread of COVID (e.g., wearing masks, distance from others, frequent testing, quarantine when testing positive, lockdowns, self-isolation when exposed). Although the question asked specifically about lingering impacts, it is not clear from the responses provided if all the mentioned COVID impacts were still happening. One respondent mentioned how COVID protocols interfered with communication, *"Frequent COVID lockdowns in the prison have disrupted the methods of information sharing and size of program."*

Health issues or concerns (15.2%) was the next most frequently mentioned theme. **Program changes or impacts** (12.8%, e.g., changes to the program rules and practices, program environment, and program success), **staff shortages** (11.5%), and **increased client economic vulnerability** (11.3%, e.g., changes in client employment, finances, housing issues, homelessness, increase in the cost of living, transportation issues) were all mentioned by just above 10% of respondents.

Less than 10% of respondents, overall, mentioned **mental health impacts** (e.g., increased anxiety or depression), **limited availability of services** (e.g., hours have been cut, more limited availability of AA/NA and other SUD groups, more limited capacity), **social changes** (e.g., loss of loved ones, increased isolation), **increased use of substances or overdoses**, **program funding changes** (e.g., less funding), **insurance changes or limits**, and **more staff working from home**.

When looking at differences between programs the most frequently mentioned themes varied a bit with lower client attendance and engagement, COVID protocols, and client economic vulnerability being mentioned most frequently in Recovery Kentucky programs while Prenatal programs more frequently mentioned COVID protocols, client economic vulnerability, telehealth and other program changes. For DOC programs staff shortages were mentioned more frequently than mentioned by the other programs.

TABLE 3.2. LINGERING IMPACTS OF COVID

% Mentioned	CMHC (n = 366)	Recovery Kentucky (n = 76)	Prenatal (n = 20)	DOC (n = 24)	Total (n = 486)
Increased Zoom and telehealth meetings and appointments	35.5%	5.3%	15.0%	29.2%	29.6%
Decreased client attendance and engagement	21.6%	42.1%	0.0%	12.5%	23.5%
Ongoing COVID protocols	13.4%	19.7%	35.0%	20.8%	15.6%
Health issues or concerns	16.9%	13.2%	10.0%	0.0%	15.2%
Program changes or impacts	10.9%	15.8%	15.0%	29.2%	12.8%
Staff shortages	12.8%	3.9%	5.0%	20.8%	11.5%
Increased client economic vulnerability	8.7%	17.1%	30.0%	16.7%	11.3%
Mental health impacts	9.6%	6.3%	10.0%	4.2%	8.0%
Limited availability of services	8.2%	2.6%	5.0%	20.8%	7.8%
Social changes	6.0%	6.6%	5.0%	0.0%	5.8%
Increased use of substances or overdose	5.5%	2.6%	5.0%	10.0%	5.1%
Program funding changes	2.5%	9.2%	5.0%	0.0%	3.5%
Insurance changes or limits	3.0%	1.3%	0.0%	0.0%	2.5%
More staff working from home	1.9%	0.0%	0.0%	10.0%	1.9%

Job Satisfaction and Burnout

As Table 3.3 shows, respondents reported high levels of satisfaction with their job, on average (4.2), and lower average ratings of burnout (1.8). There was very little variation in these ratings by program.

TABLE 3.3. JOB SATISFACTION AND BURNOUT

	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Average job satisfaction rating (1-5 with higher score higher satisfaction)	4.1	4.4	4.5	3.9	4.2
Average burnout rating (1-5 with higher score higher burnout)	2.1	1.7	1.6	1.9	1.8

Best Aspects of the Job

The majority of respondents, regardless of program, indicated that witnessing meaningful changes in clients' lives (62.9%) and contributing to positive changes in society (21.6%) were the best aspects of their job (Table 3.4). There was very little variation by program

for the best aspects of their job although more respondents from prenatal programs mentioned personal growth (17.0%) than respondents in the other programs.

TABLE 3.4. BEST ASPECTS OF THE JOB

% Mentioned	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Meaningful changes in clients' lives	62.4%	66.2%	60.4%	62.9%	62.9%
Contributing to positive changes in society	21.5%	21.5%	18.9%	28.6%	21.6%
Personal growth/continual learning	12.5%	9.2%	17.0%	2.9%	11.9%
Collegiality with colleagues	0.8%	0.8%	1.9%	2.9%	1.0%
None	2.0%	0.8%	0.0%	2.9%	1.7%
Other	0.8%	1.5%	1.9%	0.0%	1.0%

Summary of Organizational Challenges and Rewards Experienced by Program Staff

The most frequently mentioned organizational challenges were related to staffing shortages, workloads, and burnout while the least mentioned challenges were associated with harassment of clients by other clients or staff, exploitation of clients, staff having difficulty getting time off, and the agency or program not treating clients or staff very well.

Over half of respondents (58.3%) indicated there were lingering impacts from COVID. The most frequently mentioned COVID impacts included telehealth and Zoom meetings with clients and staff and lower client attendance and engagement. Next frequently mentioned were COVID protocols and health issues or concern about health.

Overall, the respondents who participated in the survey were largely satisfied with their job and had a low burnout rating, which is interesting given the frequency with which staff burnout was mentioned by respondents as an organizational challenge.

Most of the respondents reported the best aspect of their job was helping to make meaningful changes in clients' lives (62.9%) and one-fifth mentioned contributing to positive changes in society (21.6%) was the best aspect of their job.

Section 4. Key Program Performance Indicators

This section provides results for staff perceptions of: (a) demographic and key performance indicators tracked by their program/agency; (b) the most important performance indicators of program/agency success; and (c) factors clients consider when thinking about entering a SUD program.

Demographic and Key Performance Indicators Tracked by Program/Agency

Around half of respondents indicated that incarceration status (56.8%), basic resource limitations of clients (52.1%), and client race/ethnicity (48.4%) were tracked by their organization or program (Table 4.1). Fewer respondents from DOC and Recovery Kentucky programs indicated their program tracked rural versus urban residence or LGBTQ+ identity of clients than the other two programs.

TABLE 4.1. DEMOGRAPHIC INDICATORS TRACKED BY PROGRAM/AGENCY

% Mentioned	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Incarceration status *(e.g., those on probation or parole, those transitioning out of jail or prison)*	55.9%	57.7%	58.5%	65.7%	56.8%
Basic resource limitations *(e.g., homelessness)*	55.0%	45.4%	54.7%	22.9%	52.1%
Race/ethnicity	50.7%	36.9%	56.6%	37.1%	48.4%
Gender identity	49.9%	36.2%	54.7%	25.7%	47.1%
LGBTQ+ identity	45.5%	28.5%	45.3%	17.1%	41.7%
Rural versus urban residence	34.6%	23.8%	41.5%	17.1%	32.7%

Overall, respondents indicated that 8.6 performance indicators were tracked in their organization, on average, with prenatal programs tracking over 10 and the other programs tracking closer to 8 indicators (Table 4.2). The list of key performance indicators were organized by indicators related to client engagement, services, feedback and outcomes.

Of the key performance indicators assessed in the survey related to client engagement, the majority of respondents indicated their organization tracked the number of clients who enter the program (82.1%), how often clients miss appointments (72.4%), and the number of clients who drop out (71.5%). About two-thirds of clients thought their organization tracked changes to the treatment plans (65.2%), length of time clients are in the program (64.9%), and wait time for clients (63.5%).

Overall, of the service-related indicators, about two-thirds of respondents indicated their organization tracked mental health counseling use (68.1%), recovery support service use (65.1%), and coordination with medical providers (64.9%).

With regard to client feedback and outcome indicators, two-thirds (65.5%) indicated their program or agency tracked client feedback about the program while about half reported their organization followed clients after leaving the program in a systematic way (49.8%).

Within each category, only about half of respondents who reported these indicators were tracked said the results were widely shared and about half reported they were not widely shared. One program difference was that higher percentages of prenatal program staff indicated the data that was collected was shared widely for most of the indicators compared to staff from other programs. Additionally, DOC program staff indicated less tracking of retention as well as counseling and medical provider use compared to the other programs.

TABLE 4.2. KEY PERFORMANCE INDICATORS TRACKED BY PROGRAM/AGENCY

% Reported	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Average number of performance indicators tracked..	8.3	8.3	10.3	7.8	8.6
Client engagement					
Tracks the wait time for clients from first contact to assessment/treatment	62.9%	61.5%	71.7%	68.6%	63.5%
Information is collected and not widely shared	31.1%	28.5%	24.5%	20.0%	29.8%
Yes, information is transparent and shared	31.9%	33.1%	47.2%	48.6%	33.7%
Tracks number of clients who enter the program	79.7%	86.2%	92.5%	94.3%	82.1%
Information is collected and not widely shared	38.0%	27.7%	20.8%	37.1%	35.3%
Yes, information is transparent and shared	41.6%	58.5%	71.7%	57.1%	46.8%
Tracks how often clients miss appointments	73.7%	63.8%	75.5%	77.1%	72.4%
Information is collected and not widely shared	37.9%	32.3%	30.2%	34.3%	36.4%
Yes, information is transparent and shared	35.8%	31.5%	45.3%	42.9%	36.0%
Tracks the number of clients who dropout	67.6%	78.5%	88.7%	88.6%	71.5%
Information is collected and not widely shared	37.2%	32.3%	26.4%	31.4%	35.5%
Yes, information is transparent and shared	30.4%	46.2%	62.3%	57.1%	36.0%
Tracks changes to treatment plans using a standardized tool	67.0%	52.3%	79.2%	60.0%	65.2%
Information is collected and not widely shared	32.0%	28.5%	32.1%	25.7%	31.1%
Yes, information is transparent and shared	35.0%	23.8%	47.2%	34.3%	34.0%
Tracks the percent of episodes clients attend or episodes lasting 30 days or longer	65.4%	60.0%	83.0%	48.6%	64.9%
Information is collected and not widely shared	35.4%	25.4%	26.4%	22.9%	32.8%
Yes, information is transparent and shared	29.9%	34.6%	56.6%	25.7%	32.2%

TABLE 4.2. KEY PERFORMANCE INDICATORS TRACKED BY PROGRAM/AGENCY (CONT.)

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Tracks the number of clients involved in the program that overdose	46.0%	55.4%	62.3%	40.0%	48.3%
Information is collected and not widely shared	26.2%	22.3%	26.4%	25.7%	25.6%
Yes, information is transparent and shared	19.8%	33.1%	35.8%	14.3%	22.7%
Services					
Tracks mental health counseling use	70.6%	59.2%	81.1%	37.1%	68.1%
Information is collected and not widely shared	36.7%	32.3%	28.3%	20.0%	34.8%
Yes, information is transparent and shared	33.8%	26.9%	52.8%	17.1%	33.3%
Tracks client use of recovery support services	63.7%	68.5%	83.0%	48.6%	65.1%
Information is collected and not widely shared	33.2%	32.3%	30.2%	20.0%	32.3%
Yes, information is transparent and shared	30.6%	36.2%	52.8%	28.6%	32.8%
Tracks coordination with medical providers when clients give permission	64.7%	67.7%	81.1%	34.3%	64.9%
Information is collected and not widely shared	34.6%	40.8%	28.3%	14.3%	34.3%
Yes, information is transparent and shared	30.1%	26.9%	52.8%	20.0%	30.6%
Client feedback and outcomes					
Obtains feedback from clients about the program *(e.g., satisfaction surveys or other formal feedback)*	65.7%	59.2%	81.1%	62.9%	65.5%
Information is collected and not widely shared	33.3%	24.6%	28.3%	40.0%	31.9%
Yes, information is transparent and shared	32.4%	34.6%	52.8%	22.9%	33.6%
Tracks client progress *(i.e., outcomes)* after leaving the program in a systematic way for all clients	47.0%	53.1%	69.8%	57.1%	49.8%
Information is collected and not widely shared	24.6%	21.5%	34.0%	31.4%	25.0%
Yes, information is transparent and shared	22.4%	31.5%	35.8%	25.7%	24.8%

Note. Response options of no, somewhat, and don't know are not presented in the table.

Most Important Indicators of Program/Agency Success

As Table 4.3 shows, when respondents were asked to list the three most important indicators of program or agency success, four main categories were identified: indicators after clients leave the program, during the program, client feedback, and program-level indicators.

Indicators after clients leave the program were most frequently mentioned (47.1%). This

category included themes of **sobriety, recovery beyond abstinence, and aftercare engagement** with services at the same agency or at others.

For examples of **recovery beyond abstinence**, respondents mentioned:

- *"Changes in family relationships, parenting; healthy baby outcomes."*
- *"Clients gaining and maintaining employment."*
- *""Honesty, truth, independent living/having housing/sober living."*
- *"Clients staying out of jail, involvement in criminal justice system."*
- *"Quality of life improvement within 5 years of treatment."*
- *"Respondents' ability to engage in meaningful activity after completion- work/community services, etc."*
- *"Facilitation of prolonged maintenance of psychological & emotional wellness."*
- *"How many clients have their lives changed by the program for the better, even if it's not exactly what the program had laid out."*
- *"The progress of the individual and the progress of the family unit/others associated with the client."*
- *"That the client does not come back to a specialized program once in recovery."*
- *"Staying out of jail, getting a job, and becoming successful."*

As examples of **aftercare engagement**, respondents mentioned:

- *"Connection to other services for clients once they complete treatment."*
- *"Clients staying engaged in programs even after the official completion."*
- *"Clients who give back to the program."*

Client-level indicators during the program were mentioned next most frequently (38.7%) which included themes related to **attendance and program engagement** (e.g., frequency of attendance, dropout rates, client consistency, attending and engagement in counseling, AA/NA meetings, client motivation, client attitudes toward treatment) and **program completion** or graduation rates.

Client feedback was only mentioned by 14.9% of respondents with Recovery Kentucky respondents less frequently mentioning anything related to this theme than respondents from the other programs. This included any mention of client satisfaction with the

program, follow-ups with clients, clients being willing to recommend the program to others after leaving, and clients and other agencies referring others to the program.

Program-level indicators were mentioned by only about one-fifth of respondents (22.9%). That theme included any mention of **program quality** (e.g., wait times, treatment provided, providing individualized treatment plans, providing, client level resources or referrals), **staff quality** (e.g., staff behaviors, teamwork), **staff feedback** (e.g., staff satisfaction, burnout, retention), and **program profit**. The following are examples of mentions of staff quality:

- *"Leaders who lead and are there to assist when needed. We have that and it makes a HUGE difference!"*
- *"Teamwork, communication, empathetic employees, care about clients, listen, are respectful, compassionate."*

TABLE 4.3. MOST IMPORTANT PERFORMANCE INDICATORS OF PROGRAM/AGENCY SUCCESS

% Mentioned Theme	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Indicators after clients leave the program	44.2%	53.1%	52.8%	65.7%	47.1%
Sobriety	26.8%	33.8%	34.0%	42.9%	29.1%
Recovery beyond abstinence	21.6%	23.1%	24.5%	34.3%	22.6%
After care engagement	7.2%	10.8%	7.5%	11.4%	7.9%
Indicators for clients during the program	38.2%	43.1%	32.1%	40.0%	38.7%
Attendance and program engagement	21.1%	23.1%	18.9%	31.4%	21.7%
Program completion	20.2%	20.8%	15.8%	11.4%	19.6%
Client feedback	16.9%	6.2%	15.1%	11.4%	14.9%
Program level indicators	24.7%	12.3%	26.4%	25.7%	22.9%
Program quality	15.1%	7.7%	18.9%	22.9%	14.5%
Staff quality	11.4%	5.4%	9.4%	8.6%	10.2%
Staff feedback	2.1%	0.0%	0.0%	0.0%	1.6%
Program profit	0.5%	0.0%	0.0%	0.0%	0.4%

Factors Clients Consider When Thinking About Entering a SUD Program

Respondents were asked what factors they thought clients looked for when thinking about entering a SUD program and the sub-themes were organized into three overarching themes related to ***program or service preference***, ***program quality***, and ***program accessibility*** (Table 4.4).

Overall, 60.5% of respondents mentioned a theme related to ***program or service preference*** including **program approach** (31.0%), which included any mention of how clients seek programs based on how well it fits their needs and wants (e.g., program structure, rules about tobacco and/or cellphones, flexibility, size, overcrowding, drug screens, how well run the program is, methods and environment such as the cleanliness of the facility). Additionally, a few respondents indicated clients seek programs that will keep their information confidential. One respondent summarized this theme with: “That the facility is well run and clean, most of them have seen many different programs, and know what warning signs to look for.”

Help or support with basic resources was the next most frequently mentioned theme and any mention of help with needed resources (17.5%) such as housing issues or help with additional resources was included. Closely following that theme was the **length of the program** (17.3%). Less than 10% of respondents mentioned clients are looking for a **MOUD/MAT approach**, **family involvement** (e.g., visitation is allowed, children can visit or stay with them), that clients are looking for a **program that is easy to complete** or that they are looking for a **program that helps with their legal status or needs** such as any mention of helping them with the criminal justice system (e.g., it is a way out of jail, good time credit) or that they were mandated to that program.

Program quality was the next overarching theme (41.5%). **High quality staff** was included within this overall theme (28.2%) which included any mention of clients seeking programs with caring and knowable staff (e.g., compassion, trust, staff who relates, skill/credibility, friendliness, no judgment) and having staff in recovery. The two quotes below underscore this theme:

- *“If they are treated like people, not treated like a number on a checklist.”*
- *“I believe clients want to know they are cared for wherever they are at.”*

Success of the program was mentioned by 17.8% of respondents and included any mention of program success, word of mouth, recovery stories, and program accountability.

> ***“Since SUD programs have expanded greatly in the last few years, I believe that ‘word of mouth‘ is big in the client’s world. If you are in jail with someone that went to a great treatment facility everyone that is with them will want to go to that place.”***
>
> \- PROVIDER SURVEY PARTICIPANT

Program accessibility (40.1%) included any mention of accessibility or cost. Specifically, **program location** was mentioned by 20.6% of respondents, which included any mention of convenience, distance from home, transportation, being close to children and family. **Program accessibility** was mentioned by 17.9% of respondents and included any mention of how easy and/or how quickly it was for clients to get into the program including wait time, hours of operation, and how quickly they could utilize services. **Affordability** included any mention of cost or whether the client’s insurance would pay (13.6%) were also included with the overall theme. Although program approach was the first or second most frequently mentioned theme

for every program, the next most frequently mentioned varied by program with CMHC respondents suggesting clients look for high quality staff, Recovery Kentucky respondents indicated clients look for the length of time in the program, prenatal program respondents mentioned clients look for family involvement, and DOC respondents indicated clients look for convenient locations.

TABLE 4.4. FACTORS CLIENTS CONSIDER WHEN THINKING ABOUT ENTERING A SUD PROGRAM

% Mentioned Theme	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Program or service preferences	56.3%	69.2%	81.1%	71.4%	60.5%
Program approach	29.9%	34.6%	37.7%	25.7%	31.0%
Help or support with basic resources	17.7%	15.4%	18.9%	20.0%	17.5%
Length of program	12.4%	36.2%	22.6%	25.7%	17.3%
MOUD/MAT approach	8.1%	6.2%	13.2%	11.4%	8.3%
Family involvement in program	5.0%	3.1%	37.7%	5.7%	6.8%
Program is easy to complete/get through	3.6%	6.9%	1.9%	2.9%	4.0%
Program helps with legal status or needs	1.6%	3.1%	0.0%	2.9%	1.8%
Program quality	46.2%	30.0%	20.8%	34.3%	41.5%
High quality staff	34.1%	8.5%	13.2%	20.0%	28.2%
Success of the program	17.4%	22.3%	7.5%	22.9%	17.8%
Program accessibility	41.0%	32.3%	34.0%	62.9%	40.1%
Program location	19.7%	18.5%	28.3%	34.3%	20.6%
Program accessibility *(e.g., how quickly or easily someone could get an appointment)*	20.5%	8.5%	5.7%	25.7%	17.9%
Affordability	14.6%	11.5%	1.9%	20.0%	13.6%

Summary of Key Program Performance Indicators

The majority of respondents indicated their program or agency tracked the number clients who enter the program (82.1%), and around two-thirds indicated their program or agency tracked a variety of other indicators. Additionally, of respondents who indicated their program or agency tracked client engagement, service, or client feedback and outcomes, about half of them said the information was shared with staff and about half said it was not shared widely. Half or less than half indicated their organization tracked client demographics.

When asked about the most important program indicators, client-level outcomes such as relapse and aftercare engagement were most frequently mentioned, then program completion and attendance indicators, program-level indicators, and least frequently mentioned was client feedback (14.9%).

Staff indicated that clients seek SUD programs that match their preferences in some way including program approach, help or support with basic resources, and program length while program quality and accessibility were less frequently thought to be criteria for consumers' selection of programs

Section 5: Services Provided for Clients

This section provides results regarding staff perceptions of: (a) services provided for some or all clients; (b) MOUD/MAT services provided; (c) recently implemented practices to increase client engagement in SUD programs; (d) use of evidence-based practices and challenges to using evidence-based practices with SUD clients; (e) smoking cessation in SUD programs; and (f) opinions about harm reduction and harm reduction services offered.

Services Provided for Some or All Clients

As mentioned previously, the DOC program results with regard to services likely reflect the higher percentage of respondents (63%) working as community social service clinicians who assess and provide links to SUD services but who do not provide direct services. Similarly, Recovery Kentucky programs do not offer counseling in the program, but they do link clients with community-based services (Logan, Cole, & Walker, 2020; Logan, McLouth, & Cole, 2022). Linking clients with community-based services while in the program may help facilitate the transition out of the program and into independent living.

As Table 5.1 shows, the majority of respondents, overall, indicated their organization assessed client basic needs (92.0%), trauma and violence exposure (89.1%), mental health (84.6%) and physical health (79.7%). Fewer respondents in the Recovery Kentucky and DOC programs indicated their program assesses trauma and violence exposure or mental and physical health compared to the CMHCs and prenatal programs.

Most respondents indicated clients have personalized treatment plans (93.0%), continuous monitoring of treatment plans (92.1%), that they match treatment to clients (89.6%), provide mental health services for clients (81.6%), provide telehealth services (85.0%), provide individual counseling (86.4%), and provide medications to help treat addiction (72.4%). The lowest percentages for services provided were medical detoxification (32.5%) and childcare services (19.4%). Smaller percentages of Recovery Kentucky staff reported their program provided these services compared to the other programs.

Most of the respondents indicated their program also provided or helped clients with resource supports including case management or resources for basic needs (92.3%), help with health insurance (89.1%), help with ID and birth certificate documents (83.0%), and help with transportation (80.7%). Smaller percentages of DOC respondents reported their agency provided these resource supports. Fewer organizations, overall, indicated they had housing options (67.2%), offered smoking cessation (61.3%), testing for Hepatitis C, HIV or STIs (53.4%), or helped with civil (42.7%) or criminal legal (45.6%) issues.

Overall, the majority of respondents indicated that some or all clients in their organization are provided with discharge planning (94.2%) and exit assessments (89.2%) for recovery needs. Fewer respondents indicated that exit assessments are conducted with clients who drop out (64.9%), although it appears that half or more of the respondents believe at least some clients who have dropped out are interviewed by the program, except for

respondents affiliated with DOC programs, which again may be partially driven by the majority of DOC respondents worked as community SSCs.

The majority of respondents, overall, also believe their organization does outreach to individuals in need of SUD programs or treatment (73.1%) and that their organization offers interim services for clients when immediate admission is not possible (58.0%) except for DOC supported programs, where interim services in a correctional facility may not be a valid option.

About one-third of respondents (34.6%) specified interim services their program or agency offers when immediate admission is not possible (not shown in a table). The most frequently mentioned resource offered during the wait period was **referrals to other agencies or community services** (37.2%).

The next most frequently mentioned option was **putting clients in a different level of care** until they could get into the recommended level of care including outpatient, groups, and telehealth appointments (22.9%). Example responses are:

> *"Our focus is on the client. Client-centered services are essential. Addiction is a family disease and involves the family as well. "*
>
> \- PROVIDER SURVEY PARTICIPANT

- *"For example, we may enroll a client in a lower level of care (e.g., IOP) until a placement at a higher level of care (e.g., residential treatment) is available."*

- *"If a client needs inpatient services but they have children over the age of 6 months, then we can make accommodations for that individual and conduct intensive outpatient services. "*

Respondents also indicated that clients waiting for a SUD appointment were referred to **detox or to the hospital to get stabilized** (17.0%) and that clients waiting to be referred were told about **crisis management services or a crisis stabilization unit or team** if clients were or were to become in crisis while waiting (12.8%). Several respondents mentioned:

- *"Services include Mobile Crisis, walk-in emergency services, an interim treatment plan, which allows peer support workers services to begin prior to intake assessment. Services also include a 24/7 hotline and a 988-suicide line. Quick response team is also an option for some consumers. Special outreach programs exist as well."*

- *"My clinic offers emergency appointments on a walk-in basis any day during business hours. For clients who cannot be seen by a clinician, a member from the mobile crisis team will step in and conduct an appointment as needed for clients. This clinic also offers a crisis line for any person in the community (client or non-client) who is in distress and wishes to call in."*

Referring clients waiting for an appointment to **peer services** (8.0%), **AA/NA** (3.1%), and

case management (3.1%) were infrequently mentioned.

TABLE 5.1. SERVICES PROVIDED FOR SOME OR ALL CLIENTS

% Reported Services were Provided to Some or All Clients	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Assessments					
Perform comprehensive assessments for basic needs	93.3%	87.7%	98.1%	74.3%	92.0%
Assess for trauma or violence exposure	95.6%	64.6%	92.5%	60.0%	89.1%
Perform comprehensive assessments for mental health	95.4%	50.0%	83.0%	25.7%	84.6%
Assess for physical health problems	84.6%	63.1%	81.1%	54.3%	79.7%
Services					
Personalize treatment plans	97.9%	70.8%	98.1%	82.9%	93.0%
Clients receive continuous monitoring with adjustments to plan as needed	96.6%	73.1%	94.3%	80.0%	92.1%
Match treatment to client	95.4%	60.8%	90.6%	91.4%	89.6%
Individual counseling	95.9%	53.1%	92.5%	34.3%	86.4%
Telemedicine/telehealth	94.1%	57.7%	81.1%	31.4%	85.0%
Provide mental health services	95.1%	33.1%	81.1%	25.7%	81.6%
Provide medications to help treat addiction	82.6%	33.1%	73.8%	37.1%	72.4%
Family counseling	78.5%	30.0%	83.0%	8.6%	68.3%
Allow children to stay onsite or visit	57.9%	50.8%	90.6%	20.0%	57.3%
Offer medical detoxification	35.3%	22.3%	37.7%	14.3%	32.5%
Provide childcare services for clients	20.0%	10.8%	37.7%	14.3%	19.4%
Resource supports					
Provide case management or resources for basic needs	95.3%	86.9%	92.5%	60.0%	92.3%
Access health insurance	91.4%	95.4%	84.9%	31.4%	89.1%
ID or birth certificate help	85.0%	89.2%	79.2%	28.6%	83.0%
Transportation assistance	81.1%	85.4%	79.2%	57.1%	80.7%
Have housing options as part of program	64.2%	93.8%	58.5%	34.3%	67.2%
Offer smoking cessation counseling or other nicotine addiction support	64.7%	51.5%	75.5%	17.1%	61.3%
Test for Hepatitis C, HIV, and STIs	53.8%	56.2%	66.0%	17.1%	53.4%
Help with criminal legal issues	43.9%	61.5%	47.2%	14.3%	45.6%
Help with civil legal issues	41.5%	53.1%	50.9%	14.3%	42.7%
Discharge/recovery supports					
Do discharge planning	96.4%	94.6%	88.7%	62.9%	94.2%
Perform exit assessments for recovery needs	90.4%	91.5%	96.2%	48.6%	89.2%
Perform exit assessment for individuals who have dropped out	68.9%	50.0%	81.1%	25.7%	64.9%

TABLE 5.1. SERVICES PROVIDED FOR SOME OR ALL CLIENTS (CONT.)

% Reported Services were Provided to Some or All Clients	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Client engagement efforts					
Outreach to individuals who need SUD programs/ treatment but have not initiated...	78.7%	56.9%	66.0%	45.7%	73.1%
Offer interim services for clients when immediate admission is not possible..............	62.3%	48.5%	47.2%	34.3%	58.0%

Table 5.2 show services or referrals offered to some or all clients while they are in the SUD program and as a part of aftercare. Peer support workers (89.9% during the program and 77.0% as part of aftercare), trauma education and safety planning (88.1% during the program and 80.1% as part of aftercare), Naloxone and overdose education (81.5% during the program and 74.4% as part of aftercare) were the three most frequently mentioned services offered for some or all clients for both periods, although fewer of the DOC program staff indicated these services were offered/referred compared to the other three programs.

TABLE 5.2. SERVICES OR REFERRALS OFFERED DURING THE PROGRAM OR AS PART OF AFTERCARE

% Reported Services or Referrals Offered for Some or All Clients	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
During the program...					
Peer support workers during treatment	96.4%	73.8%	94.3%	28.6%	89.9%
Trauma education and safety planning..........	93.7%	71.5%	92.5%	45.7%	88.1%
Naloxone and overdose education	84.1%	74.6%	88.7%	51.4%	81.5%
Recovery capital scale or other assessment to help with recovery needs	77.1%	56.9%	77.4%	51.4%	72.9%
AA/NA groups...	65.4%	96.9%	83.0%	45.7%	70.6%
Employment assistance	72.5%	62.3%	69.8%	37.1%	69.3%
Mutual-help recovery groups other than AA/NA	68.0%	62.3%	66.0%	45.7%	66.0%
Housing assistance..	63.4%	81.5%	56.6%	28.6%	64.3%
As part of after care					
Trauma education and safety planning..........	84.1%	68.5%	84.9%	45.7%	80.1%
Peer support workers......................................	83.4%	62.3%	71.7%	25.7%	77.0%
Naloxone and overdose education	77.2%	70.0%	71.7%	45.7%	74.4%
Recovery capital scale or other assessment to help with recovery needs	70.9%	56.2%	71.7%	60.0%	68.2%
Employment assistance	68.0%	71.5%	60.4%	42.9%	67.0%
AA/NA groups...	56.3%	93.1%	64.2%	40.0%	61.8%
Mutual-help recovery groups other than AA/NA	61.3%	61.5%	50.9%	34.3%	59.5%
Housing assistance..	56.1%	83.8%	49.1%	28.6%	58.8%

Although most, if not all, programs have access to a language line to help serve non-English speaking clients, having staff on-site for language interpretation may help facilitate SUD program engagement. As noted in Table 5.3, close to or over half of the respondents at CMHCs, prenatal, and DOC programs indicated their organization had sign language interpreters (56.9%) while just over a quarter of Recovery Kentucky programs did. Fewer from each program indicated their programs had on-site Spanish (29.1%) or other language staff counselors (33.1%).

TABLE 5.3. ON-SITE LANGUAGE SERVICES PROVIDED

% Reporting Yes	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Sign language interpretation	63.9%	26.9%	54.7%	48.6%	56.9%
Non-English services provided by staff counselor (not Spanish)	35.9%	20.8%	24.5%	42.9%	33.1%
Spanish language provided by staff counselor	31.4%	22.3%	17.0%	31.4%	29.1%

MOUD/MAT Services Provided

Table 5.4 shows that the majority of respondents from CMHCs, prenatal, and DOC programs indicated their organization provides the option of MOUD/MAT (67.6% overall). About one-third (33.8%) of Recovery Kentucky programs indicated they accommodated MOUD/MAT.

Of respondents who indicated their organization had the option, the majority of respondents indicated their organization had written policies and procedures (97.0%). Other services provided are also shown including medically supervised withdrawal management (70.8%) and induction services (94.0%). Buprenorphine and Naltrexone were mentioned more frequently for both. About half of the respondents, overall, indicated clients are required or encouraged to taper or discontinue MOUD prior to discharge (50.8% overall, except for prenatal or DOC programs) while almost half of respondents, overall, indicated their organization had a policy that limited or capped the maximum dose of MOUD (44.9%).

TABLE 5.4. MOUD/MAT SERVICES

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Organization provides the option of Medication for Opioid Use Disorder (MOUD)/ Medication Assisted Treatment (MAT)	73.5%	33.8%	83.0%	65.7%	67.6%
Of those that provide MOUD/MAT	n = 452	n = 44	n = 44	n = 23	n = 563
Organization has written policies and procedures regarding MOUD/MAT	97.8%	84.1%	100%	100%	97.0%
Organization provides medically supervised withdrawal management					
No	41.4%	52.3%	34.1%	73.9%	43.0%
Yes, with comfort medications only	27.7%	36.4%	27.3%	0.0%	27.2%
Yes, with agonist and comfort medications	31.0%	11.4%	38.6%	26.1%	29.8%
Type of induction services your organization provides					
None	4.9%	13.6%	2.3%	21.7%	6.0%
Of those that provide induction services:	n = 430	n = 38	n = 43	n = 18	n = 529
Buprenorphine (Suboxone, Subutex)	89.9%	60.5%	97.7%	50.0%	87.0%
Naltrexone or extended-release naltrexone	67.4%	65.8%	88.4%	88.9%	69.7%
Extended-release buprenorphine (Subclade)	44.7%	31.6%	81.7%	38.9%	46.7%
Methadone	17.2%	7.9%	23.3%	11.1%	16.8%
Type of MOUD maintenance clients can be on when they enter the program					
None	5.5%	2.3%	0.0%	21.7%	5.5%
Of those that allow MOUD maintenance:	n = 427	n = 43	n = 44	n = 18	n = 532
Buprenorphine (Suboxone, Subutex)	91.3%	65.1%	100%	77.8%	89.5%
Naltrexone or extended-release naltrexone	69.8%	69.8%	90.9%	77.8%	71.8%
Extended-release buprenorphine (Subclade)	62.1%	39.5%	95.5%	72.2%	63.3%
Methadone	42.2%	14.0%	61.4%	55.6%	41.9%
Clients are required or encouraged to taper or discontinue MOUD at any point prior to program discharge	53.3%	52.3%	36.4%	26.1%	50.8%
The organization has a policy that limits or caps the maximum dose for buprenorphine or methadone maintenance for clients	49.1%	43.2%	20.5%	13.0%	44.9%

Recently Implemented Practices to Increase Client Engagement in SUD Programs

As shown in Table 5.5, there were three response options for each service asked about: (1) no, they do not offer this service; (2) yes, this service is offered and it was implemented within the past year; and (3) yes, this service is offered, and it was implemented more than one year ago. Table 5.5 shows the percent of respondents who gave the first and second response options.

The hiring of staff with specialized skills (e.g., Spanish speaking staff, 49.3%) and being flexible with appointment times (25.7%) were most frequently mentioned as not being implemented. Two-fifths of staff from Recovery Kentucky and DOC reported that harm reduction was not implemented, whereas under one-fifth of CMHC staff and one-twentieth of staff in prenatal programs reported that harm reduction was not implemented. It's important to keep in mind that respondents were not provided a definition of harm reduction.

Expanding treatment options (23.3%) and the use of specific treatment strategies (24.6%) were most frequently mentioned as being implemented within the past year. Both Recovery Kentucky and DOC program staff rated these services or practices a bit differently as expected.

Although very few respondents indicated there were other recently implemented practices to increase client engagement, a few did specify some recent practices. These practices included drop-in centers for youth, working to better meet needs for veterans, several mentioned having peer support workers available after hours or having clients meet with peer support workers before entering the program, increasing outreach activities, and one described trying to bring more services together for pregnant mothers in one place. Additionally, a few mentioned organizing fun activities for clients and/or clients and their families such as a family fun night once a month or organizing social activities or a social club.

TABLE 5.5. RECENTLY IMPLEMENTED PRACTICES TO INCREASE CLIENT ENGAGEMENT IN SUD PROGRAMS

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Reducing Barriers to Program Engagement					
Outreach to vulnerable populations					
No, do not offer	15.6%	28.5%	13.2%	57.1%	19.1%
Yes, offer and implemented within the past year	22.8%	21.5%	17.0%	14.3%	21.1%
Be flexible with appointment times *(e.g., evenings, weekends)*					
No, do not offer	23.4%	30.0%	20.8%	57.1%	25.7%
Yes, offer and implemented within the past year	24.1%	21.5%	18.9%	14.3%	22.9%

TABLE 5.5. RECENTLY IMPLEMENTED PRACTICES TO INCREASE CLIENT ENGAGEMENT IN SUD PROGRAMS (CONT.)

% Reported	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Focus more on providing or linking clients with basic resources					
No, do not offer	5.0%	11.5%	1.9%	11.4%	6.1%
Yes, offer and implemented within the past year	19.0%	27.7%	18.9%	17.1%	20.3%
Addressing Adaptation Barriers					
Be flexible with service options *(e.g., groups for specific populations, services for hearing impaired or LGBTQ+)*					
No, do not offer	21.1%	32.3%	5.7%	28.6%	22.2%
Yes, offer and implemented within the past year	18.5%	20.0%	17.0%	17.1%	18.6%
Target treatment to specific populations					
No, do not offer	17.9%	40.0%	9.4%	48.6%	22.1%
Yes, offer and implemented within the past year	19.7%	19.2%	15.1%	8.6%	18.8%
Expand treatment options *(e.g., specialized groups)*					
No, do not offer	20.5%	36.2%	15.1%	28.6%	22.9%
Yes, offer and implemented within the past year	24.4%	20.8%	17.0%	22.9%	23.3%
Provide harm reduction services					
No, do not offer	17.6%	41.5%	5.7%	40.0%	21.5%
Yes, offer and implemented within the past year	20.8%	27.7%	20.8%	17.1%	21.7%
Hired more diverse staff *(e.g., LGBTQ+)*					
No, do not offer	15.3%	17.7%	11.3%	37.1%	16.3%
Yes, offer and implemented within the past year	22.4%	19.2%	32.1%	17.1%	22.3%
Hired staff with specialized skills *(e.g., Spanish speaking)*					
No, do not offer	46.0%	60.8%	56.6%	54.3%	49.3%
Yes, offer and implemented within the past year	19.3%	16.9%	11.3%	20.0%	18.5%
Hired more staff who are in recovery					
No, do not offer	10.6%	2.3%	1.9%	50.0%	10.0%
Yes, offer and implemented within the past year	22.0%	16.9%	26.4%	17.1%	21.2%
Hired peer support workers in recovery					
No, do not offer	5.9%	14.6%	1.9%	37.1%	8.3%
Yes, offer and implemented within the past year	20.7%	25.4%	24.5%	48.6%	22.8%
Addressing Program Quality					
Expand the use of specific treatment strategies					
No, do not offer	11.5%	30.0%	0.0%	28.6%	14.4%
Yes, offer and implemented within the past year	24.4%	25.4%	22.6%	28.6%	24.6%
Improve clinical skills and knowledge					
No, do not offer	6.8%	23.8%	1.9%	8.6%	9.2%
Yes, offer and implemented within the past year	20.7%	27.7%	22.6%	17.1%	21.7%

TABLE 5.5. RECENTLY IMPLEMENTED PRACTICES TO INCREASE CLIENT ENGAGEMENT IN SUD PROGRAMS (CONT)

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Education and collaboration outside our agency					
No, do not offer	12.4%	18.5%	1.9%	14.3%	12.7%
Yes, offer and implemented within the past year	19.2%	18.5%	17.0%	17.1%	18.8%

Note. The response option, “Yes, offered and implemented more than a year ago” is not shown in table.

Evidence-based Practices and Challenges to Using Evidence-based Practices with SUD Clients

Respondents were asked about what evidence-based practices they or staff persons in their organization used frequently or with most/all clients (Table 5.6). The most frequently mentioned practices included relapse prevention (82.7%) and peer support workers (79.4%). Although there were few differences across programs for relapse prevention services, however, a smaller percentage of DOC staff mentioned peer support workers.

TABLE 5.6. EVIDENCE-BASED PRACTICES USED FREQUENTLY OR WITH MOST/ALL CLIENTS

% Reported Used Frequently or With Most/All Clients in Organization	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Relapse prevention services	83.3%	79.2%	84.9%	82.9%	82.7%
Peer support workers	83.6%	70.0%	86.8%	28.6%	79.4%

Recovery Kentucky programs do not typically provide mental health counseling as a part of their program. Thus, results of evidence-based mental health practices are shown only for CMHCs, prenatal, and DOC respondents (Table 5.7). On average, respondents indicated they used 7.3 evidence-based practices. Prenatal program respondents had the highest average number of evidence-based practices while DOC respondents indicated the lowest average number.

Cognitive behavioral therapy (84.1%), motivational interviewing (80.9%), Seeking Safety (66.1%), mindfulness-based relapse prevention (63.9%), and motivational enhancement therapy (51.8%) were most frequently mentioned. The least frequently mentioned evidence-based practices included Prolonged Exposure (17.6%), Eye Movement Desensitization and Reprocessing (EMDR) (23.2%), community reinforcement and vouchers, and Skills Training in Affective and Interpersonal Regulation (STAIR) (24.6%). Smaller percentages of DOC staff reported use of many of the evidence-based practices (with the exception of motivational interviewing), likely due to the number of Community Social Service Clinicians who make referrals rather than providing direct service.

TABLE 5.7. EVIDENCE-BASED MENTAL HEALTH PRACTICES USED FREQUENTLY OR WITH MOST/ALL CLIENTS

% Reported Used Frequently or With Most/All Clients in Organization	CMHC (n = 615)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Average number of evidence-based practices	7.5%	9.0%	5.3%	7.3%
Mentioned more frequently				
Cognitive behavioral therapy	85.7%	79.2%	62.9%	84.1%
Motivational interviewing	80.7%	77.4%	91.4%	80.9%
Seeking Safety	67.2%	73.6%	37.1%	66.1%
Mindfulness-based relapse prevention	63.9%	75.5%	45.7%	63.9%
Motivational enhancement therapy	51.9%	67.9%	25.7%	51.8%
Mentioned by less frequently				
Matrix model	49.3%	39.6%	31.4%	47.7%
Dialectical behavioral therapy	43.6%	56.6%	20.0%	43.4%
Cognitive processing therapy	42.0%	52.8%	22.9%	41.8%
Functional analysis/self-observation	40.7%	56.6%	31.4%	41.4%
Contingency management/motivational incentives	35.1%	56.6%	48.6%	37.4%
Family behavior therapy	34.0%	52.8%	14.3%	34.4%
Rational emotive behavioral therapy (REBT)	32.2%	37.7%	20.0%	32.0%
Skills Training in Affective and Interpersonal Regulation (STAIR)	24.4%	37.7%	8.6%	24.6%
Community reinforcement plus vouchers	23.1%	34.0%	22.9%	23.9%
Eye Movement Desensitization and Reprocessing (EMDR)	23.9%	26.4%	5.7%	23.2%
Prolonged Exposure (PE)	17.1%	30.2%	8.6%	17.6%

There were a number of challenges to using evidence-based practices as noted in Table 5.8. Across the programs, respondents indicated 5.1 average challenges to using evidence-based practices, with DOC respondents indicating the highest number of challenges and prenatal program respondents indicating the lowest number of challenges.

In particular the lack of training in evidence-based practices (62.2%), lack of time to learn or refresh evidence-based practices (62.0%), client acceptance of evidence-based practices (60.3%), and lack of confidence in implementing evidence-based practices (55.8%) were most frequently mentioned.

TABLE 5.8. SOMEWHAT OR DEFINITELY A BARRIER TO USING EVIDENCE-BASED PRACTICES WITH SUD CLIENTS

% Reported Somewhat or Definitely a Barrier	CMHC (n = 615)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Average number of challenges to using evidence-based practices	5.6	3.4	6.3	5.1
Mentioned by more than half of respondents overall				
Lack of training	63.9%	37.7%	68.6%	62.2%
Lack of time to learn/ refresh evidence-based practices	63.9%	34.0%	71.4%	62.0%
Client acceptance of evidence-based practices	60.0%	50.9%	80.0%	60.3%
Lack of confidence in staff skills	57.4%	30.2%	65.7%	55.8%
Mentioned by less than half of respondents overall				
Costs related to evidence-based practices materials or resources	50.6%	30.2%	48.6%	48.9%
Many evidence-based practices are too complicated to implement	45.9%	30.2%	54.3%	45.1%
Insurance will not reimburse	46.5%	26.4%	31.4%	44.2%
Limited support for evidence-based practices or new evidence-based practices	45.5%	26.4%	42.9%	44.0%
Many evidence-based practices have conflicting or limited evidence	37.4%	26.4%	42.9%	36.8%
There are no evidence-based practices for their client population	17.1%	3.8%	20.0%	16.2%
There are no evidence-based practices for the types of services the program provide *(e.g., they don't provide counseling)*	13.7%	5.7%	28.6%	13.8%

Smoking Cessation in SUD Programs

Respondents were also asked their thoughts on addressing smoking in SUD programs. As Table 5.9 shows, the majority of respondents, regardless of SUD program, believed that offering help (74.8%) with smoking cessation rather than ignoring or forcing smoking cessation was the best option for clients. Respondents were in agreement regardless of program type. A minority of the entire sample (17.0%) agreed with the statement that SUD programs have enough to focus on and clients can work focus on their nicotine addiction later.

TABLE 5.9. SMOKING CESSATION/NICOTINE ADDICTION IN SUD PROGRAMS

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
With regard to smoking cessation/nicotine addiction do you think:					
SUD programs have enough to focus on and clients can focus on nicotine addiction later	16.6%	23.1%	13.2%	8.6%	17.0%
SUD programs should offer help with smoking cessation if clients want it	75.4%	70.0%	73.6%	82.9%	74.8%
SUD programs should insist clients work on stopping smoking as an integrated part of treatment	3.4%	4.6%	9.4%	5.7%	4.1%
SUD programs should ban smoking in facilities and expect abstinence	0.8%	0.0%	0.0%	2.9%	0.7%
Have thoughts other than what was listed above	3.7%	2.3%	3.8%	0.0%	3.4%

Opinions About Harm Reduction and Harm Reduction Services Offered

Respondents were asked whether they believe SUD programs should focus on harm reduction or focus on abstinence. In the survey, harm reduction was defined as minimizing negative health, social and legal impacts associated with substance use. Thus, the specific type of harm reduction was not specified in the first set of questions.

Regardless of program, most respondents indicated they believed SUD programs should offer both harm reduction and abstinence-based options depending on the client needs (80.1%, Table 5.10). Several respondents summarized their thoughts about harm reduction with these quotes:

- *"I think that both should be available but separated. The abstinence-based facility that I work for has no place for the substances used to medically treat addiction. I do believe that medical treatment should be an option for those that would be best served in that way."*

- *"I believe that all forms of recovery are necessary to best serve the population. No program is a fix all for all clients and just as MOUD should be an option in some programs, I believe total abstinence should be an option in others."*

If respondents said they did not think harm reduction should be offered, then they were asked to explain why. Overall, 29 people (3.5%) provided a response to this question. Of those, 58.6% mentioned that **harm reduction does not work** and 37.9% indicated that **harm reduction does not fix addiction** (not shown in a table). The following statements are examples:

- *"Harm reduction is just trading one problem substance for another."*
- *"I strongly feel like treating substance use disorders with a substance is ignorant. If harm reduction is the goal, the MAT is suitable. If recovery, freedom from active addiction, is the goal then abstinence is the only way to achieve that. Offering MAT services is giving clients more barriers than they already have."*
- *"Harm reduction is poorly defined in social services. I have had people tell me clean needles is harm reduction. I have had people tell me a place to shoot up is harm reduction. I have had people tell me that daily cannabis use is harm reduction. In my opinion, there is no difference in daily cannabis use and daily use of any other mood-altering substance - for instance alcohol. Daily use of alcohol for most people at certain substantial levels is unhealthy. I believe the same about cannabis, therefore it is not harm reduction. I think MAT is effective. I prefer buprenorphine/naloxone over methadone. I do not think that anyone is essentially opioid deficient and needs opioid supplements for the remainder of their lifetime. I believe they can be stabilized on a lower dose of medication and very slowly, almost imperceptibly tapered off of the medication over the course of a year or so. Similarly, I do not think that anyone is alcohol, cannabis, benzodiazepine, opioid, amphetamine, methamphetamine, or hallucinogenic deficient and therefore does not need supplements of these substances for a lifetime for 'Harm Reduction.'"*
- *"I have seen the harm reduction models at other places where I have worked, and it does not work. Clients just continue to use and do not respect others who are trying to stay sober, and it makes it hard for clients and staff to put clear cut boundaries about use in place."*

When asked why the respondent thought harm reduction should be offered or why they thought both options should be offered (see Table 5.10), most respondents (71.6%), across all of the program types, indicated they thought **the approach should depend on the clients' needs and preferences** as noted in the following quotes:

- *"I have worked in the substance use field for years and I personally have family members who have struggled with substance use disorders. I have found that ...they may not want to quit completely and if they are required to maintain abstinence, then they won't seek treatment or might be less open to it. I feel that it is more beneficial to meet the consumer where they are at and work forward from there."*
- *"Recovering from active addiction does not look the same for all people. You have to take into account so many different variables (e.g., trauma, extent of use, education, want); thus a cookie-cutter approach will not work. Some clients may be responsive to abstinence-based treatment while*

> ***"The negative harm caused by substance use is what makes it a disorder, and preventing that harm is the goal of treatment, not just being sober. Some people can achieve that from moderation; others need to not use it at all, and like all things in mental health that should be determined on a case-by-case basis whenever possible."***
>
> \- PROVIDER SURVEY PARTICIPANT

others may need to begin/maintain harm reduction strategies to regain healthy living habits and lead productive lives. "

- *"There is no 'one size fits all' approach when it comes to individuals and their needs. I think a comprehensive assessment needs to be conducted between a client and the professional, and client based treatment planning should determine if abstinence-based support is more appropriate or if harm reduction is more appropriate."*
- *"Every client is different. It is a disservice to use a 'cookie-cutter' approach to serve all clients, not every client has the same background or same present circumstances. There are definitely similarities among clients but insisting that everyone can be served in the exact same way is the opposite of meeting a client 'where they're at.' Some clients need an abstinence-only approach, but other clients benefit greatly from an approach of harm reduction."*

- *"I feel that both are important depending on the client because some clients cannot grasp the fact that they will be taking no mind-altering substances and feel if they are only drinking alcohol instead of injecting heroin that is a success in their eyes. Clients measure success at different rates and instead of harping about one thing or the other we have to meet clients where they are at. I think it is important to not push your beliefs of sobriety off on others but to ask what are their beliefs and preferences? Once we make strides with that then we can encourage maybe stopping the alcohol, it's all client based. What are my client's needs in this instance? They are holding a job, going to meetings, going out with friends but they aren't overdosing every other day, well that is harm reduction. Obviously, there are repercussions of alcohol, but we can deal with the lesser of two evils for now. Some people don't have that all or nothing mentality of I am going to stop everything, it's all about meeting individuals' needs and reducing the most imminent danger in their life at that moment."*

The second most frequently mentioned theme was that **harm reduction can help people until they can become abstinent** (11.7%). The following examples represent this theme:

- *"I am not against harm reduction. I just know from my own personal experiences that I tried using Suboxone for years and thought it would save me. That was until I wanted to get 'higher.' I think harm reduction is good for people if they have a taper plan to come off of the maintenance medications."*

- *"Some clients aren't ready for total sobriety but are at risk of dying due to their current use. Harm reduction gives these clients the opportunity to seek abstinence in the future. Without harm reduction, they might not have that future."*

Several other themes were mentioned by less than 5% of respondents, including **they do not believe abstinence-only approaches work at all, mental health must be addressed regardless of treatment approach**, and that **clients need to be educated about recovery and treatment options**. A few clients mentioned **MOUD/MAT works** while others mentioned **MOUD/MAT does not work**, and a few respondents mentioned

both **abstinence-based and MOUD/MAT approaches are important but not at the same facility** (e.g., residential).

TABLE 5.10. HARM REDUCTION AND ABSTINENCE-ONLY APPROACHES

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Respondent believes that SUD programs should focus on harm reduction rather than abstinence only					
No, I think programs should have abstinence-based services/philosophy only...	5.0%	13.8%	5.7%	0.0%	6.2%
Yes, I think programs should focus on harm reduction services/ philosophy instead of abstinence-based	12.7%	9.2%	17.0%	17.1%	12.6%
Both, I think programs should focus on both harm reduction and abstinence-based depending on the client	81.6%	74.6%	73.6%	82.9%	80.1%
Of respondents who indicated they thought programs should focus on harm reduction or on both harm reduction and abstinence	n = 386	n = 76	n = 20	n = 22	n = 504
% Mentioned Theme					
Approach should depend on client needs and preferences	72.0%	71.1%	75.0%	63.6%	71.6%
Harm reduction can help people until they can become abstinent	12.7%	9.2%	15.0%	0.0%	11.7%
Abstinence-only approach does not work	3.1%	1.3%	5.0%	13.6%	3.4%
Mental health must be addressed regardless of treatment approach	3.6%	1.3%	10.0%	0.0%	3.4%
Must educate clients about recovery and treatment options	2.3%	5.3%	0.0%	9.1%	3.0%
MOUD/MAT works	1.0%	7.9%	0.0%	9.1%	2.4%
MOUD/MAT does not work	1.0%	2.6%	5.0%	4.5%	1.6%
Abstinence-only and MOUD/MAT approaches both work but must be in separate facilities	0.5%	1.3%	10.0%	4.5%	1.0%

Table 5.11 shows results for whether specific harm reduction strategies are offered in their program/agency and respondents' thoughts about whether they should be offered. The majority of respondents thought Naloxone kits and training is, and should be, offered (72.7%), almost half indicated sex education and sexual health options are offered and should be offered (46.5%), and just over forty percent (41.9%) indicated fentanyl tests are and should be offered.

Around 40% of respondents indicated that injection supplies are not and should not be offered and 28.7% thought Pre-Exposure Prophylaxis (PrEP) is not and should not be offered. Almost half of the respondents (48.3%) indicated that PrEP is not offered but should be along with 40% who thought injection supplies are not but should be offered. These results suggest that SUD staff are split in their thoughts about some harm reduction strategies.

When examining results by program there were a few differences. More DOC program staff suggested that although Naloxone kits and training as well as Fentanyl tests are not currently offered they should be compared to the other three programs (where more of them do offer this and agree it should be offered). Additionally, sex education was more frequently mentioned by respondents from DOC programs as something that is not offered but should be compared to the other programs.

TABLE 5.11. HARM REDUCTION SERVICES OFFERED IN RESPONDENT'S PROGRAM/AGENCY

% Reported	**CMHC (n = 615)**	**Recovery Kentucky (n = 130)**	**Prenatal (n = 53)**	**DOC (n = 35)**	**Total (n = 833)**
Naloxone kits and training					
No, do not offer and should NOT be offered	6.8%	8.5%	1.9%	8.6%	6.8%
No, do not offer but should be	16.3%	13.8%	7.5%	42.9%	16.4%
Yes, offers this, but think they should NOT be offered	3.9%	5.4%	1.9%	2.9%	4.0%
Yes, offers this and respondent thinks they should	73.0%	72.3%	88.7%	45.7%	72.7%
Fentanyl tests					
No, do not offer and should NOT be offered	15.1%	16.9%	9.4%	11.4%	14.9%
No, do not offer but should be	39.7%	32.3%	30.2%	48.6%	38.3%
Yes, offers this, but think they should NOT be offered	3.7%	8.5%	9.4%	5.7%	4.9%
Yes, offers this and respondent thinks they should	41.5%	42.3%	50.9%	34.3%	41.9%
Free syringes/needles service					
No, do not offer and should NOT be offered	33.8%	63.1%	49.1%	51.4%	40.1%
No, do not offer but should be	43.6%	27.7%	34.0%	42.9%	40.5%
Yes, offers this, but think they should NOT be offered	3.1%	3.8%	5.7%	0.0%	3.2%
Yes, offers this and respondent thinks they should	19.5%	5.4%	11.3%	5.7%	16.2%

TABLE 5.11. HARM REDUCTION SERVICES OFFERED IN RESPONDENT'S PROGRAM/AGENCY (CONT.)

% Reported	CMHC (n = 615)	Recovery Kentucky (n = 130)	Prenatal (n = 53)	DOC (n = 35)	Total (n = 833)
Free injection supplies (alcohol swabs, tourniquet, cooker and sterile water)					
No, do not offer and should NOT be offered	40.3%	61.5%	49.1%	54.3%	44.8%
No, do not offer but should be	43.3%	27.7%	35.8%	40.0%	40.2%
Yes, offers this, but think they should NOT be offered	2.9%	3.8%	1.9%	0.0%	2.9%
Yes, offers this and respondent thinks they should	13.5%	6.9%	13.2%	5.7%	12.1%
Sex education, safe sex materials, STI testing and treatment					
No, do not offer and should NOT be offered	13.7%	16.2%	5.7%	31.4%	14.3%
No, do not offer but should be	37.2%	27.7%	5.7%	48.6%	34.2%
Yes, offers this, but think they should NOT be offered	4.7%	6.2%	5.7%	5.7%	5.0%
Yes, offers this and respondent thinks they should	44.4%	50.0%	83.0%	14.3%	46.5%
Pre-exposure prophylaxis (PrEP)					
No, do not offer and should NOT be offered	26.0%	39.2%	28.3%	37.1%	28.7%
No, do not offer but should be	51.4%	39.2%	35.8%	45.7%	48.3%
Yes, offers this, but think they should NOT be offered	2.4%	5.4%	3.8%	8.6%	3.2%
Yes, offers this and respondent thinks they should	20.2%	16.2%	32.1%	8.6%	19.8%

Summary of Services Provided for Clients

Respondents, regardless of program, reported their program/agency conducts comprehensive assessments, personalizes treatment plans and offers a variety of services and resource supports, and they do discharge planning with clients. Over half of the respondents (58%), overall, indicated that while clients are waiting for a SUD appointment their organization offers interim services. About one-third of respondents indicated what kind of interim services are offered during the waiting period and those services included referrals to other agencies or community services, putting clients into a different level of care than needed as a beginning, referring or telling clients about detox, stabilization at the hospital, or crisis lines/services . Referring clients waiting for an appointment to peer services, AA/NA, and case management were infrequently mentioned as something done for clients while waiting for an appointment.

Most, if not all, programs have access to a language interpretation line to serve non-English speaking clients, but on-site language services are less common at around half having sign language services and one-third having staff counselors who speak languages

other than English.

Additionally, around three-quarters of clients indicated that peer support workers, trauma education and safety planning, Naloxone and overdose education, assessments of recovery needs, AA/NA, and help with employment are offered both during the program and as part of after care for some or all clients.

About two-thirds of respondents indicated their agency provides or allows for MOUD/MAT services with lower rates reported by Recovery Kentucky and DOC staff than for the other two types of programs.

When asked about practices to increase client engagement, the most frequently mentioned as being implemented in the past year were expanding treatment options (23.3%) and the use of specific treatment strategies (24.6%). The hiring of staff with specialized skills (e.g., Spanish speaking staff, 49.3%) and being flexible with appointment times (25.7%) were most frequently mentioned as not being implemented at all in their program/agency.

The majority of respondents indicated they used relapse prevention and peer support workers in their program. Additionally, respondents indicated they or their organization offered between 5 and 9 specific mental health evidence-based practices. They also reported an average of 5 challenges with using evidence-based practices such as lack of training, limited time to learn or refresh evidence-based practices, lack of confidence, and concern with clients accepting some of the evidence-based practices they thought might be useful.

Most respondents agreed that for both smoking cessation and harm reduction options, client needs and preferences should be considered a priority. Additionally, the largest proportion of respondents thought that injection supplies are not offered and should not be offered (40%-45%) in their program while PrEP was the next most frequently mentioned as not being offered (and should not be offered) in their program (28.7%). On the other hand, the most frequently mentioned harm reduction services that are, and should be, offered are Naloxone kits and training (72.7%), sex education (46.5%) and fentanyl tests (41.9%). These results suggest that SUD staff are divided in their thoughts about some harm reduction strategies such as PrEP and injection supplies.

Limitations

There are several limitations to this project. Although the sample size was large, the sample included individuals working in various roles in a variety of SUD programs. Examining staff perceived barriers for individuals providing direct services to clients such as clinicians and therapists by program type may be an important next step. Because of the varied types of programs, the research team did not define program type for respondents, which means that respondents used their own definitions. For some respondents, when they considered whether their organization provided services or had specific challenges, they may have been thinking of their particular program whereas other respondents may have been thinking of the continuum of SUD services provided within their county or CMHC region. Additionally, because different programs use different terminology and processes, it may be important to consider focus groups or additional in-depth interviews to contextualize findings. For example, the results from questions about what services were provided by their program or agency may have included referrals to specialized services rather than specific to agency/program services but it is difficult to know how respondents answered these questions. There were also specific programs and regions that did not have any or many staff who participated, making the results less generalizable.

Conclusions and Recommendations

Because of providers' vantage point of working within the systematic and programmatic constraints and resources, their perspective is less focused on individual experiences. Rather, provider experiences give a broader perspective and include the experiences of many clients as well as a more in-depth understanding of organizational and workforce issues that impact the accessibility, availability, and adaptability of SUD services. For this reason, providers in a variety of publicly-funded SUD programs were surveyed about their perceptions of barriers to SUD program engagement as well as their own barriers to working with SUD clients.

Overall results of the provider survey show that respondents consistently ranked clients' personal barriers such as lack of motivation as more significant than systemic or program level barriers. However, personal barriers can be impacted by systemic, program, and resource barriers, which may be less apparent to individuals who are not directly experiencing them (i.e., less apparent to providers than to clients).

Client resource barriers such as lack of stable and safe housing, transportation problems, social support, and difficulty meeting basic needs were frequently mentioned as barriers to SUD program engagement. Research suggests that clients who come into SUD programs with fewer resources are less likely to complete the program and they are more likely to relapse and have other negative recovery outcomes (e.g., criminal justice system involvement, sustained economic vulnerability, mental health problems) (Logan & Cole, 2023; Logan, Cole, & Schroeder, 2022; Logan, Cole, & Walker, 2020; Logan, McLouth, & Cole, 2022). The complex and persistent interplay of poverty, racism, gender-based violence, community violence, stigmatization of SUDs results in reduced employment opportunities, less stable housing, greater vulnerability to physical and mental health conditions, and social alienation and isolation. Recovery encompasses all aspects of an individuals' life, as noted in one of the guiding principles of recovery (i.e., "recovery is holistic") in SAMHSA's working definition of recovery (SAMHSA, 2012). Meaningful connections between service systems that can help with these interwoven social problems are needed to provide clients with the resources, safety net, and support to facilitate significant progress in their recovery.

Additionally, one-third of staff reported hearing about negative experiences clients had with SUD programs in the past. As shown in the data tables from the Performance Indicators Project Report, just over one-half (54.3%) to two-thirds (67.7%) of individuals coming into treatment programs and who participated in one of three studies (KTOS, RCOS, CJKTOS) have been in SUD programs prior to program entry. Thus, program barriers that may seem minimal to staff working in the programs may have a more negative impact on clients with prior negative experiences.

Both systemic factors and the way relapse is handled within a program can interfere with program engagement and recovery. Systemic barriers such as the cost of treatment, limitations imposed by insurance, and legal issues can increase client stress and reduce program engagement. These factors can also interfere with staying in a program. Additionally, sanctions and termination because of relapse were noted as a particularly

concerning challenge to working with clients because relapse is a part of recovery and punishing clients for relapse may set them back unnecessarily.

Staff also face a number of challenges to working with SUD clients such as staff shortages, high caseloads, challenges to implementing evidence-based practices, and burnout. Addressing staff challenges may help them better support and engage clients. One way to do this may be to gather staff feedback in a systematic way that also encourages them to speak openly about their challenges. Additionally, providing staff with opportunities and resources to expand their skills and education can be rewarding in multiple ways.

Peer support workers were overwhelmingly noted as being extremely helpful to clients. Additionally, providers mentioned several key benefits for peer support workers themselves, for current clients who have access to peer support workers, and to the program itself in that peer support workers help with clients, but they are also able to take on tasks that other staff cannot. Several key concerns related to peer support workers were also mentioned including the need to support them in meaningful ways, the importance of educating and providing them with skills training, and the need for supervision.

Most staff rated client-level outcomes or program success as the most important program performance indicators while only a few mentioned client feedback. Perhaps past efforts at obtaining client feedback have not been very informative because client satisfaction surveys are notoriously biased toward positive results. The conditions under which client feedback is collected have an impact on the results. The most honest feedback is provided in contexts when potentially negative feedback will not jeopardize relationships or be perceived as having negative repercussions for the client. Thus, anonymous or confidential methods for collecting client feedback are important for reducing bias in responses. Furthermore, without a systematic way of collecting feedback from all/most clients, the individuals who volunteer to provide feedback tend to be the individuals with the most extreme experiences because they are the most motivated to share their perspective: the most satisfied and the least satisfied. Thus, collecting feedback in a systematic and regular manner may be key to gathering a more accurate view of the range of clients' experiences.

When asked what staff believed consumers consider in selecting a SUD program, the majority indicated clients look for program approach and length while quality and accessibility were thought to play a lesser role in selection. The fact that providers believe that program quality plays a lesser role in consumers' selection of programs may be more a product of the difficulty of obtaining this information than the usefulness of this information if it were available to potential consumers. Increased education for consumers about program approaches, quality, and success is important in helping them find the right match to the program. Finding the right match is a challenge under the best of conditions, but attempting to do this without useful and accurate information is even more difficult. Clients entering programs that are not a good fit for them will increase the likelihood that they will disengage and possibly have poorer outcomes. Each failed experience can undermine a person's sense of hope and self-efficacy that recovery is possible for them. Hope plays an essential role in recovery, according to SAMHSA's (2012)

working definition, "Recovery emerges from hope" and "Hope is a catalyst for recovery." Thus, actions that SUD programs and providers can take to facilitate clients' appropriate match to treatment/programs to maximize the likelihood of success should be implemented. Additionally, helping clients with what to expect from a program when they first make an appointment could also help clients better adjust and prepare themselves for the specific program they have selected.

One group of barriers that may need particular attention are the adaptability barriers. In addition to client needs and preferences, clients may have special circumstances that need to be considered in SUD program including mental health problems, physical health problems, disabilities, criminal justice system involvement, or being a part of a marginalized group (e.g., race/ethnicity, LGBTQ+). For example, racial diversity is lower in the KTOS and RCOS samples than in the general population of Kentucky (US Census Bureau, 2023). However, it's important to note that the proportion of clients who are racial/ethnic minorities varies significantly by CMHC region and the counties in which the Recovery Kentucky programs are located. For example, CMHC regions with the highest percentage of KTOS clients reporting at intake their race was other than White include: Four Rivers Behavioral Health (14.0%), Seven Counties, Inc. (14.6%), LifeSkills, Inc. (12.6%), Communicare, Inc. (12.4%), and New Vista (11.8%). Given the variability of racial diversity in different regions of the state, close attention to the racial make-up of clients in regions should be monitored at the regional level to determine if there are disparities in entering and staying in SUD programs by racial groups. Also, the KTOS, RCOS and CJKTOS data from Project 1 show that only 15%-19% of clients that come into those programs are 18-25 years old and only 7.0%-11.4% are ages 50 and older, meaning a significant portion of consumers in the younger and older age groups of adulthood may be struggling with addiction on their own. Innovative strategies need to be developed to engage persons of racial minorities and younger and older age groups.

Most staff indicated that abstinence-based versus harm reduction should be decided depending on the client needs and preferences, which is consistent with one of the guiding principles of recovery: "recovery occurs via many pathways" (SAMHSA, 2012). Nonetheless, some staff had strong and conflicting opinions about which approach is best as well as regarding specific harm reduction strategies that should be incorporated into SUD programs.

Several recommendations were developed based on the provider survey results. First, addressing systemic, program, and resource barriers may be a pathway to increasing client engagement by reducing interference with staying in a program as well as to increasing motivation for recovery and engaging in the program. At the very least, it may be helpful for clients if staff acknowledged the challenges clients face with getting to and staying in the program. Assessing or offering ongoing support directly or through referrals could help clients as needs and barriers may change over time. Regular check-ins with clients about their potentially changing needs and resources, if they are not already occurring in the course of treatment, may improve the responsiveness of SUD programs to clients.

Second, programs could more widely share information that is tracked about the program

to their own staff. In particular, clients should have an opportunity to provide feedback to program administrators and staff on various aspects of their experiences including the use of evidence-based practices, particularly given that about two-thirds of staff thought a challenge to using evidence-based practices is client acceptance.

Third, it is important to recognize and acknowledge that staff are sometimes divided about the best approaches to SUD programs, although the majority of respondents agree that it is important to meet the client where they are with regard to smoking cessation as well as using harm reduction strategies to support recovery. Whatever the program focus is, clients should be educated about what to expect so they can choose a SUD program approach that fits their needs and preferences. Having educated choices in program selection may help clients with motivation.

Fourth, peer support workers provide a valuable service in SUD programs. Agencies experience high staff turnover, high caseloads, and must operate within strict and constraining billing regulations; thus, there is an incentive to turn to peer support workers to fill in gaps that may not be appropriate for their expertise and training. Considerable investment and effort need to be put into training, education, supervision and support for peer support workers, as well as with clinical staff about the role of peer support workers so that peer support workers are not overburdened or put into situations that are outside of their appropriate role. Additionally, it is important to have a program culture and options for peer support workers who are struggling with their own recovery to be honest and open with their supervisors without fear of losing their employment.

Fifth, more creative and innovative strategies need to be considered to address specific client needs, vulnerabilities, and preferences within the same program or more education for clients in selecting specific programs approaches within their resource constraints (e.g., location or distance to travel, time conflicts). Greater flexibility in approaching a client's recovery with a harm reduction approach versus abstinence-only may be possible in outpatient counseling in a way that would be more difficult to implement in group-based settings such as residential and intensive outpatient treatment. In other words, a therapist meeting for individual counseling with clients may have greater flexibility in working with multiple clients with very different approaches.

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Appendix A. Region/Program Staff Participation Rates

TABLE A1. SPECIFIC REGION/PROGRAM INFORMATION

CMHC Regions	**N = 615**	**N**
Adanta Group	1.3%	8
Communicare, Inc.	4.6%	28
Comprehend, Inc.	2.3%	14
Cumberland River Behavioral Health	4.4%	27
Four Rivers Behavioral Health	8.9%	55
Kentucky River Community Care	5.2%	32
LifeSkills, Inc.	4.4%	27
Mountain Comprehensive Care Center	16.3%	100
New Vista	7.0%	43
North Key Community Care	4.6%	28
Pathways, Inc.	24.4%	150
Pennyroyal Center	3.9%	24
River Valley Behavioral Health	5.5%	34
Seven Counties Services	7.3%	45

Recovery Kentucky Programs	**N = 130**	**N**
Brighton Center for Women	3.1%	4
CenterPoint of Paducah for Men	4.6%	6
Cumberland Hope Community Center	0.0%	0
Genesis Recovery Center	6.2%	8
George Privett Recovery Center	4.6%	6
Healing Place- Men's program	14.6%	19
Healing Place -Women's program	10.0%	13
Healing Place of Campbellsville	6.9%	9
Hope Center for Women	3.1%	4
Hickory Hill Recovery Campus	6.2%	8
Liberty Place Recovery Center for Women	8.5%	11
Men's Addiction Recovery Campus (M.A.R.C.)	0.8%	1
Owensboro Regional Recovery Center for Men	10.0%	13
Sky Hope Recovery Center	3.8%	5
Transitions Grateful Life Center	1.5%	2
Trilogy Center	6.9%	9
Women's Addiction Recovery Manor (W.A.R.M.)	9.2%	12

Prenatal Programs	**N = 53**	**N**
Appalachian Restoration Project	0.0%	0
Chrysalis House	39.6%	21
UK HealthCare Perinatal Assistance and Treatment Home (PATHways) Program	11.3%	6
Volunteers of American Mid-States	49.1%	26

TABLE A1. SPECIFIC REGION/PROGRAM INFORMATION (CONT.)

DOC Program Type	**N = 35**	**N**
Substance Abuse Program (DOC) Prison Program	34.3%	12
Substance Abuse Program (DOC) Jail Program	0.0%	0
Substance Abuse Program (DOC) Community Custody	2.9%	1
Community custody/social service clinician (SSC)	62.9%	22