Center on Drug and Alcohol Research

Strengthening Lifelines:
Increasing Client Engagement and Retention in Substance Use Disorder Programs

Video Discussion Guide[1]

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Discussion Guide Introduction

Purpose of the Discussion Guide

This discussion guide is a companion to the video: *Strengthening Lifelines: Increasing Client Engagement and Retention in Substance Use Disorder Programs*.

Three individuals with a history of substance use disorder discuss the barriers and process of entering and engaging in SUD programs.[2, 3] Providers and individuals in recovery also provide their thoughts throughout each video chapter. The overall themes of the video are grounded in national and Kentucky research that is described in the video context and summary sections of the discussion guide. Additionally, Appendix C provides a more in-depth summary of the results and recommendations generated from four studies on barriers to SUD program engagement in Kentucky.

This discussion guide has three main objectives including to provide:

(1) contextual information and research underlying the key themes in the video;
(2) questions to guide discussion in response to the video themes as a whole as well as for each of the five video chapters; and
(3) infographic handouts summarizing themes from the video.

How to Use the Discussion Guide

The video is organized into five chapters. Each chapter in the discussion guide is briefly reviewed and then discussion questions are presented. The goal of the discussion questions is to facilitate thought and discussion regarding the unique barriers that potential and current clients may experience in your agency/program in order to identify unique solutions. Please make your own judgment about whether any of the questions are useful or whether you would prefer to generate your own questions. Discussion questions are also provided for the video as a whole.

[2] These individuals portrayed in the video were actors who used information generated from interviews with individuals who have been in SUD programs. Actors were used to protect confidentiality of individuals with SUDs. However, all other voices in the video are individuals engaged in SUD recovery or are SUD program peer supports, staff, and administrators.

[3] The stories represented on the video may not be representative of all individuals who need, want, or have entered SUD programs. SUD program clients come from many different backgrounds, many of which were not represented in the video. Individuals each have unique situations and barriers that may not have been identified in our prior research or highlighted in the video itself. Further, there are many barriers that have been documented nationally and through targeted research studies in Kentucky (described in the video context section as well as in Appendix C) that were not included in the video, in part, to keep the video to approximately 60 minutes.

Acknowledgments

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Video Context

Nationally, substance use has increased over time despite significant efforts and funding targeting reductions in substance use and overdose risks. Despite significant efforts to address substance use disorder (SUD)s in the United States, overall prevalence rates have remained largely stable or have increased in recent years. Similarly, Kentucky continues to have some of the highest rates of overdose deaths in the U.S. (Centers for Disease Control, 2022a; 2022b).

Participation in SUD programs can and does make a significant difference in helping people with recovery. Using nationally representative data, one study found that of adults reporting ever having a problem with alcohol or drug use, the majority reported being in recovery (Jones, Noonan, & Compton, 2020). Three key findings from that study have significant implications for addressing SUDs including: (1) individuals who reported ever being in SUD treatment were twice as likely to report being in recovery; (2) self-reported mental health problems were significantly associated with use of substances, while reduction of mental health symptoms was associated with reduction in use of substances; and (3) given the importance of both SUD treatment and mental health services for recovery, addressing barriers to service access and utilization is crucial.

Staying in a SUD program for at least three months is associated with better recovery outcomes. Research suggests that program completion and/or a longer length of stay is associated with greater abstinence and overall better recovery outcomes over time (Bernstein et al., 2015; Choi et al., 2015; Greenfield et al., 2003; Lappan, Brown, & Hendricks, 2019; Malivert et al., 2012; Simpson, Joe, & Rowan-Szal, 1997). One study found that the minimal mean length of program stay that separated no improvement from reliable change was 37 days, but the most reliable change for well-being and recovery was more likely to occur at the 90-day threshold (Turner & Deane, 2016), which has been noted in other research (Nsimba, 2007).

Research estimates that around 80% of individuals disengage from the treatment process between calling to make a first appointment and completing 30 days in a SUD program. In general, SUD programs have three main steps including: (1) making that phone call for help; (2) completing the intake and assessment; and (3) engaging in the SUD program for at least 30 days (Loveland & Driscoll, 2014). One study found that only 20% of people who called about substance use disorder treatment ended up completing 30 days of treatment (residential and outpatient). As shown in Infographic 1 (see Appendix A), the findings about the attrition rates at each level of care when applied to 100 individuals who call for a first appointment mean that 45 do not show up for the intake appointment. Of the 55 who show up for the first appointment, 46 are referred to treatment (and 9 are not). Of the 46 people who show up for the intake assessment and are referred to treatment, 15 do not show up for a treatment appointment. Among the 31 who show up to treatment, 20 will be in treatment for at least 30 days (Loveland & Driscoll, 2014). These rates are consistent with other studies (Andersson et al., 2018; Lappan et al., 2019; Loveland & Driscoll, 2014; White & Kelly, 2011).

In general, SUD programs have three main steps including: (1) making that phone call for help; (2) completing the intake and assessment; and (3) engaging in the SUD program for at least 30 days

3 critical points of engagement:

First phone call **Program intake** **30 days complete**

It is critical that intensity, length and type of treatment and recovery services are determined through a **comprehensive individualized assessment**. Those mutually agreed upon services must be continuously reviewed because **individuals progress through treatment at various rates**. The intensity and type of treatment and/or recovery supports needed **may change over time**.

In Kentucky, over half to two-thirds of clients who completed intake surveys in three outcome evaluation studies have been in SUD programs before: 56.2% for Kentucky Treatment Outcome Study (KTOS), 67.7% for Recovery Center Outcome Study (RCOS), and 72.0% for Criminal Justice Kentucky Treatment Outcome Study (CJKTOS) (Cole, Logan, White, & Scrivner, 2023a; 2023b; Staton & Tillson, 2024). Among individuals with prior SUD program exposure, KTOS clients had an average of 2.7 prior SUD treatment episodes, RCOS clients had an average of 3.6 prior episodes, and CJKTOS clients had an average of 4.4 prior episodes.

Recovery outcomes go beyond reductions in use of substances and risk of overdose and can include increased client quality-of-life as well as reductions in societal costs. The economic costs of substance misuse and disorders are exorbitant with one study estimating costs of substance misuse are around 3.73 trillion dollars (Recovery Centers of America, 2020). Recovery extends beyond abstinence from substances to include enhancements in physical health, mental well-being, employment, quality-of-life, and community reintegration as well as reductions in healthcare costs and criminal justice system involvement (Kaskutas et al., 2014; Laudet & White, 2008; Peterson, Li, Xu, Mikosz, & Luo, 2021; Recovery Centers of America, 2020; Richardson et al., 2018). A recent review of the economic benefits of SUD treatment found that one of the largest categories of cost savings from SUD treatment includes reductions in criminal activity and criminal justice costs (Fardone et al., 2023).

What are some barriers to engagement in Kentucky SUD programs? Documenting programmatic and systemic barriers that could be addressed with policy changes and/or targeted funding may be an important step in helping more people engage in SUD programs. Several studies and activities were undertaken as preliminary research that informed the video content. This includes four original data collection studies conducted in FY 2023 and several activities carried out in FY 2024. Additionally, the research team that developed the video has a history of conducting outcome evaluations for SUD programs.

Documenting programmatic and systemic barriers that could be addressed with policy changes and/or targeted funding may be an important interim step in helping more people engage in SUD programs.

Specifically, for the past two decades, the state of Kentucky has partnered with the University of Kentucky Center on Drug and Alcohol Research (UK CDAR) to provide outcome evaluations of SUD programs that focus on community treatment (Kentucky Treatment Outcome Study [KTOS]), criminal justice treatment (Criminal Justice Kentucky Treatment Outcome Study [CJKTOS]), and recovery programs (Recovery Center Outcome Study [RCOS]) as well as other SUD program studies. These outcome studies provide client-level performance indicators such as return to use rates annually and across time as well as increases or decreases in other indicators of recovery (e.g., mental health symptoms, living conditions, quality-of-life ratings, victimization). Extensive annual reports are generated that show change over time for clients served annually along with longitudinal trends (Cole, Logan, White, & Scrivner, 2023a; 2023b; Cole, Logan, Tillson, Staton, & Scrivner,2023).

These reports show that SUD programs in Kentucky help many people with SUDs. However, despite this unique evidence base, the existing evaluation infrastructure does not address program-level performance indicators or information about the unmet needs of individuals with SUDs in the state who may not be accessing or engaging in services. In addition, it is not clear what service gaps exist within the state treatment structure that could be leveraged to reach additional people and to keep individuals engaged in treatment to completion.

Building on the existing evaluation infrastructure at UKCDAR, four original studies conducted in FY 2023 resulted in five reports including: Performance Indicators Project (Project 1); Provider Survey Project (Project 2); Consumer Survey Project (Project 3); Secret Shopper Project (Project 4), and an overall report summarizing cross cutting themes and recommendations. A brief description is provided below, and a more in-depth summary is provided in Appendix C.

- The Project 1 report synthesizes the results of a literature review of program quality indicators for SUD programs, SUD program quality indicators collected in Kentucky, and secondary data analysis across three treatment outcome studies: (1) community treatment (Kentucky Treatment Outcome Study [KTOS]), (2) criminal justice treatment (Criminal Justice Kentucky Treatment Outcome Study [CJKTOS]), and (3) recovery programs (Recovery Center Outcome Study [RCOS]). The Project 1 report also presents performance indicator profiles for each CMHC region as well as examples of profiles of performance indicators for Recovery Kentucky, CMHC, and Department of Corrections Substance Abuse Program (DOC SAP) (Cole, Logan, Tillson, Staton, & Scrivner, 2023).

- Project 2 surveyed 833 providers in SUD programs to examine personal, program, and systemic barriers to client engagement in SUD programs as well as agency/program barriers that make it more difficult to effectively work with SUD clients (Logan, Cole, Johnson, Scrivner, & Staton, 2023).

- Project 3 conducted interviews with 62 consumers with SUDs to understand the restrictions and barriers at the program level that discourage treatment entry and/or engagement from the perspectives of individuals with SUD, and to explore person-

level barriers to treatment related to SUD program entry or dropout (Staton, Tillson, Logan, Scrivner, & Cole, 2023).

- The Project 4 report provides results of the Secret Shopper Project for each CMHC region, four prenatal programs, and for two referral lines. This integrated report shows the outcomes of the Secret Shopper project for all of the CMHC regions and also for the four prenatal programs as a whole (Logan, Johnson, Cole, Scrivner, & Staton, 2023).

- The overall report summarized results of the four studies that serve as an important interim step in identifying barriers to SUD program engagement and making recommendations to reducing some of those barriers as well as other steps that need to be taken to fully identify and document barriers to SUD program engagement. The integrated conclusions and recommendations for the four research projects are organized in response to five main questions. Overall recommendations are noted as well (Logan, Cole, Staton, & Scrivner, 2023).

Several key activities were undertaken in FY 2024 in preparation for the creation and production of the video including:

- Walkthroughs with directors and staff of three CMHCs (New Vista, Comprehend, Inc., and Cumberland River Behavioral Health) to understand the step-by-step process of becoming a client in SUD treatment. Notes of the discussion were written up and thematic analysis was conducted across all three of the programs.

- Extensive literature review of SUD program barriers;

- Development of main messages, scripts, and content for the video;

- Focus groups with SUD clients and recovery coaches included in the video;

- Interviews with program staff and key state leaders included in the video; and

- Collaboration with the video production company.

Introduction to Video Chapters

SUD program engagement begins with the first phone call and many people do not show up for the scheduled appointment. Other individuals disengage between the intake/assessment process to the first treatment or care session. Then, the next critical phase for engaging clients is from initiation of treatment to engaging for at least 30 days in the program.

The video is 63 minutes total and, consistent with the program engagement process steps, is divided into 5 main chapters:

Chapter 1: Introduction: 11:03 minutes
Chapter 2: First phone call: 15:37 minutes
Chapter 3: Intake and assessment process: 7:02 minutes
Chapter 4: Maintaining engagement in the program: 23.13 minutes
Chapter 5: Conclusion: 6:41 minutes

Each chapter in this guide presents the objective of the video chapter, a brief outline of content, and discussion questions. Infographics that help summarize the main themes are included in Appendix A.

Chapter 1: Introduction

Goal

To provide contextual information for the themes presented in the video.

Content Outline

> *"...so much of what happens in our lives depends on the care and intentions of others. In a moment like this, if Brandon had not had the fear of death to insist emphatically for help, if Joe at the desk hadn't pointed out Brandon's desperation, if Brandon's sponsor hadn't showed up for him from the beginning, Brandon might not be with us today. There are so many places in our various addiction treatment systems and bureaucracies where a simple decision, gesture, dismissal, or outright rejection tips the balance between life and death."*
>
> — Amy C. Sullivan (2021). *Opioid Reckoning: Love, Loss, and Redemption in the Rehab State*. University of Minnesota Press: MN.

1. Millions of Americans suffer with substance use disorders.

2. SUD treatment saves lives.

3. Staying in a program for at least 3 months has been associated with better recovery outcomes.

4. Unfortunately, many people do not engage in treatment. Approximately 80% disengage between first phone call and 30 days of the program. MOUD/MAT programs also have adherence concerns. Infograph 1.1 summarizes SUD treatment disengagement.

5. A common idea is that clients who do not engage are not motivated. It's important to realize that barriers, even small ones, can impact a person's motivation. Some barriers can be managed with interventions that do not necessarily cost anything other than a referral, time, or creativity.

6. Program staff are the heart of the program (not just clinicians or therapists, but everyone who encounters clients, from the people who work the front desk to janitors).

7. There are 3 critical points of engagement:

3 critical points of engagement:

First phone call **Program intake** **30 days complete**

It is critical that intensity, length and type of treatment and recovery services are determined through a **comprehensive individualized assessment**. Those mutually agreed upon services must be continuously reviewed because **individuals progress through treatment at various rates**. The intensity and type of treatment and/or recovery supports needed **may change over time**.

Chapter 1: Discussion Questions

1.1. What do you think is/are the main message(s) of the quote above? For context, in the book, Brandon is the author's son-in-law who had a history of opioid use disorder, years of recovery, and recent return to use before trying to get back into treatment.

1.2. What factors do you think impact client motivation to engage in SUD programs?

1.3. What do you think are three reasons that clients disengage from the program before completing 30 days

1.4. Do you think the reasons clients disengage from the program before completing 30 days is different depending on the population? For example, criminal justice system involved versus non-criminal justice system? Women compared to men? Younger people compared to older people?

1.5. What populations does your agency/program have more difficulty engaging?

1.6. What steps or strategies has your agency/program tried in order to increase client engagement? Do/did these changes apply across all populations equally?

1.7. What do you think your agency/program should do to increase client engagement in your program? It can be helpful to talk through a process for how to approach making changes.

Goals	Needed resources	Potential community partners	Possible support mechanisms

1.8. Thinking specifically about different populations, what needs do you think criminal justice-referred clients have that are different from non-criminal justice referred clients? Does your agency/program do anything differently with criminal justice-referred clients compared to clients who are not referred by the criminal justice system?

1.9. What adaptations has your agency/program made for particularly stigmatized and vulnerable populations? How does your agency/program do outreach or let members of these vulnerable groups know about your services?

1.10. Looking at infographic 1, in your opinion, in which step are clients in your agency/program most likely to disengage?

1.11. How does your agency/program monitor or track disengagement numbers in each of these steps?

Chapter 2: First Phone Call

Goal

The phone call is the first step in engaging the client in the SUD program. Even if potential clients do not show up to the scheduled appointment, the secondary goal is to make the initial agency/program contact a positive experience which may increase the likelihood that they will re-engage in SUD services later and more quickly than they would have if the phone call was more negative.

Even if potential clients do not show up to the scheduled appointment, the secondary goal is to make the initial contact a positive experience, which may increase the likelihood that they will re-engage in SUD services later and more quickly than they would have if the phone call was more negative.

Main Questions

- What do potential clients think about when making that first call for help?
- Why would someone not show up for their appointment after the first phone call?
- During that first phone call, how can providers make people feel more comfortable to start services?

Content Outline

- What do potential clients think about when making that first call for help? See infographic 2.1 for a summary.
    - It takes tremendous courage to make that first call for help. Many people have to overcome anxiety and fear when reaching out for help. They may be thinking: "Will I be judged or treated well? Will I be able to do it or will I fail?"
    - A sense of urgency exists when individuals reach out for help. The survival part of the brain that takes over during the addictive process may overtake the person's more rational thinking again if they have to wait long for a first appointment. It is important to provide assistance when individuals are asking for it because of the impact of substance use disorders on the brain.
    - Additionally, the risk of overdose is high, making it urgent to get those individuals seeking help into care quickly.
    - Many of the people who start a new program have had both positive and negative past experiences in SUD programs, and those experiences can influence their fears and anxiety, or hope, as they embark on this new experience.
    - Outreach may be particularly crucial for facilitating program engagement among vulnerable individuals.

- Why would someone not show up for the first appointment?
    - When clients do not show up or disengage from the program, many jump to the conclusion that they are just not motivated for treatment. Program barriers and lack of personal resources can reduce motivation.
    - Specifically, there are practical barriers that may hinder program engagement right from the start. Some of the most commonly mentioned barriers are transportation, time and other responsibilities (e.g., employment, children/childcare, stable housing).
    - Other barriers include feeling overwhelmed with all of the life demands that need to be managed in addition to the program requirements.
    - Program barriers can also reduce program engagement. For example, in the video, the caller (Noah) did not feel the staff person who answered the call was caring or compassionate. Callers who perceive that the staff person is following a structured protocol without connecting to them in a more personal way may decide the program will not be a good fit for them.
    - Some programs reach out to individuals who do not show up to their appointments to find out the reason and to assess if there is anything they could do to facilitate the person making an appointment. Even if the person does not take up the program on the offer, the staff person has created a connection that the person may pursue when their situation changes.

- How can providers help people feel more comfortable to start services?
    - It is important to consider the first impression consumers may have based on that first phone call.
        - Did they feel stigmatized and judged or did they feel warmth and caring? Did they feel listened to?
        - Did their anxiety and fear increase after that call, or did they feel more confident that this is the right place and the right decision for them?
        - Did they have to wait days for that first appointment or were they able to get in quickly?
            - Some providers have implemented walk in hours/open appointment times, telehealth appointments, or appointments at satellite offices.
            - The first call also provides an opportunity to screen for risks such as overdose and pregnancy. Program staff can provide information and referrals to individuals who screen positive (e.g., where to obtain Narcan, referrals to prenatal care, referrals to a program that can get them in sooner (if necessary) or that may better meet their needs).

Chapter 2: Discussion Questions

2.1. Try to put yourself in a consumer's shoes by walking through the initial phone call procedure (i.e., what happens when consumers make the first call for treatment) for your agency/program. Some things to consider when doing the walk through:

- What kind of customer service training do staff receive?
- Is there training and emphasis on how voice tone and other subtle nuances can make a difference in how welcoming (and anxiety reducing) that first phone is for clients?
- Is there a standard script for phone calls? If so, what training do staff receive to adapt the script to the caller's affect, situation, and stated needs?
- What questions are asked during that first phone call?
- Are screening or information and referrals provided? Infographic 2.2 displays some ideas for screening and referrals that could be included in the first phone call.
- What is the current wait list? What is the policy regarding time to appointment? What happens if that cannot be achieved?
- What quality control procedures are used to ensure the first phone call follows the script and is welcoming and comforting to clients?

2.2. What do you think are the main messages the agency/program should convey to potential clients in the first phone call? What are the best ways to deliver these messages?

2.3. What are three things that you believe are most helpful during that first phone call to engage clients in the program?

2.4. What is your best guess (or even better, what does your agency/program data indicate) on the percent of people who make that first phone call but who do not show up to the first appointment in your agency/program?

2.5. What quality control and tracking methods does your agency/program use to gauge how clients experience that first phone call and whether or not your agency/program protocols are being followed?

2.6. What screening is conducted during the first phone call within your agency/program (e.g., identifying higher risk individuals)?

2.7. What opportunities do you think exist during that first phone call to help people at risk of overdose or who need SUD treatment? What are your thoughts about the suggestions listed in Infographic 2?

2.8. What information, referrals or resources are shared with callers during the first phone call? In other words, what information, referrals, or resources are provided to callers, in case they do not show up for the first appointment?

2.9. How might the first phone call and next steps to enter treatment differ for someone under criminal justice supervision?

2.10. Thinking about the training that staff receive in responding to potential clients' calls for information and making first appointments, how could the training process be improved?

Chapter 3: Intake and Assessment Process

Goal

Identify how the program intake and assessment process may facilitate, or hinder, client engagement in the program.

Main Questions

- How do clients feel about the program intake process?
- What happens when clients' needs or wants are different from treatment recommendations?
- What happens when clients do not make it to this appointment?

Content Outline

- How do clients feel about the program intake process? See infograph 3.1 for a summary.
  - The intake process can be a burden for clients, and they may see it as interfering with them receiving the care they need. They may also feel they are asked the same questions repeatedly. It is important to educate them about why the paperwork and assessments are necessary.
    - It may be important to look for ways to reduce/streamline intake burden, or to defer elements of the process to a second, third, or later session to allow clients to receive some of the direct service they are seeking during the first appointment.
  - Clients also want, and perhaps expect, to get into care quickly, but that isn't always possible.
    - Some providers are linking peer support staff with clients as quickly as possible (e.g., right after the first phone call, before or immediately after the intake).
- Asking clients about their goals for their lives and what else is going on in their lives is important to fully engage them and to better understand their many needs, demands on their time and energy, and resources they have in their lives and how these will impact their treatment.
  - How do staff handle the situation when clients' preferences differ from treatment recommendations?
  - When clients are not allowed to select a treatment pathway that meets their needs and expectations, their motivation to participate may decrease and their recovery may be hindered. The therapist's rationale for their specific recommendations should be shared with the client. Discussing clients' expectations of treatment early in the process and discussing any discrepancies between the clients' expectations, needs, and treatment recommendations is important.
  - Harm reduction strategies may provide an important option for some clients.

Meeting clients where they are and providing person-centered care increases treatment engagement. Educating clients about all of their options and explaining the different modalities offered may facilitate program engagement.

- What happens when clients do not make it to this first appointment?
  - Stigma, fear and anxiety as well as feeling overwhelmed with life demands may impact whether a person will show up or not. Self-stigma is a potent demotivating factor. Sharing messages of hope and encouragement with clients can begin to decrease self-stigma.
    - Some programs use re-engagement specialists to reach out to those clients that do not show up in order to see if they can address barriers or other reasons clients are not showing up.

Sharing messages of hope and encouragement with clients can begin to decrease self-stigma.

Chapter 3: Discussion Questions

3.1. How long is the usual wait for the first appointment in your agency/program? How long is the total time before clients actually start treatment (i.e., participate in services that are not about assessment)?

3.2. What does the intake and assessment process at your agency/program look like? Can you think of ways to streamline or to make the process easier for clients?

3.3. How does the intake process differ for clients who are, and who are not, involved in the criminal justice system (e.g., on probation or parole)? What strategies can be used to reduce the tension between what the SUD program requires and what the criminal justice system requires for clients (if there is any)?

3.4. How do you educate and collaborate with clients about treatment type, schedule, other things to optimize the client-treatment match and increase client engagement?

3.5. What happens if the client does not believe the recommended level of care in your program is doable or a good fit for them given their limited resources and life demands? Is there a standard protocol for this or is it deal with on a case-by-case basis?

3.6. During the program intake processes, when are clients invited to share decision-making?

3.7. What happens if the client does not show up for that first appointment without any notice?

3.8. What would be needed for your agency/program to implement some of these outreach efforts for clients who do not make it to the first appointment?

3.9. Infographic 3 describes considerations and opportunities for the intake and assessment process. What are your thoughts about the suggestions? What would you add based on your experience?

Chapter 4: Maintaining Engagement in the Program

Goal

Explore factors that keep clients engaged in the program, in other words, what keeps them coming back.

Main Questions

- What keeps clients engaged in the program services?
- How do you know if you are meeting clients' needs, particularly for clients with unique needs?

Content Outline

- What keeps clients engaged in the program services? See infographics 4.1 and 4.2 for a summary.
  - Client engagement in program services is facilitated by three aspects of client-centered care: (1) respecting client autonomy through shared decision making; (2) facilitating community and belonging; and (3) promoting competence for recovery.

1. Respecting client autonomy through shared decision making
   - Shared decision-making may look different depending on the agency/program. In essence, the question is about how clients experience the rigidity of program rules vs. the ability for clients to make choices consistent with their needs, values, and interests.

2. Facilitating community and belonging
   - Agencies/programs use a variety of strategies to help clients build a supportive community and sense of belonging.
   - Some examples of strategies that increase support for clients include: ensuring a positive therapeutic alliance (and policies for when clients do not feel connected to their assigned therapist), peer support services, working with families, and hosting substance-free, fun events, gatherings, or activities.
     - One provider works with clients on how to talk to their children about their substance use risks.
     - Other providers have activities and social gatherings for clients to learn to have fun while sober.

3. Promoting competence for recovery
   - Navigating life demands, the program requirements, and recovery can be overwhelming and result in clients feeling like they can't succeed.
   - When people worry about basic resources or live in a chaotic situation, it can be difficult to focus on developing skills for recovery and being fully engaged in a program.

        - Being flexible, promoting understanding among program staff about how hard it is to change one's behavior while addressing addiction and managing life demands with limited resources. Helping clients access resources is important.
        - Learning to effectively advocate for oneself is a critical skill that individuals will have at varying levels when they begin treatment. Integrating skill building for self-advocacy into therapy/groups could improve clients' capacity to navigate the complex and sometimes conflicting demands on their lives in the present and in the future.
        - Development of aftercare services, or linking clients to aftercare, as they prepare to complete SUD programs is essential. Without continued support, such as housing assistance, employment opportunities, recovery groups, many clients will end up in risky situations that will greatly increase their risk of return to substance use.

- How do you know if you are meeting clients' needs, particularly for clients with unique needs?
    - Identifying and attending to special needs may include providing culturally responsive care, trauma-informed care, and addressing the unique needs of individuals within the criminal justice system.
    - Ensuring practices are tailored to your program's particular client populations, such as rural residents, veterans, parents with children, individuals with comorbid mental health disorders, persons with no/limited English proficiency, etc.
        - One provider matches peer support like veterans with veterans.
    - It's important to have mechanisms to obtain feedback to ensure these practices and strategies are reaching the desired impact and not creating unintended negative consequences or barriers.
    - Ensuring a way for clients to provide honest feedback about program barriers they are experiences may be important.
        - One provider has a comprehensive feedback system including a secret shopper protocol.

Chapter 4: Discussion Questions

4.1. In your opinion, what are the main reasons clients who start the program leave before completing at least 30 days of treatment? How do you/your agency/program know the main reasons that clients leave treatment early? In other words, where does this kind of information come from?

4.2. How might reasons for dropping out of the program differ among clients who are involved in the criminal justice system (e.g., on probation or parole) compared to clients not involved in the criminal justice system?

4.3. What special efforts are made to ensure clients stay in the program? How do these efforts change depending on clients' needs, interests or values?

4.4. What data is collected about treatment entry and retention by the agency/program? Thinking of the data you collect, can you think of an example of how this type of data led to changes in practice/policies in the agency/program?

4.5. Are there certain characteristics among clients that make them more vulnerable to disengaging from the program? Describe why these characteristics/situations increase their vulnerability..

4.6. What are the benefits of having peer support persons in your agency/program? What are some drawbacks or concerns with having peer support persons in your agency/program?

4.7. What happens in your agency/program if someone relapses within the first 30 days of treatment? What do you think should happen?

4.8. Infographic 4a-4c identifies factors that can increase or decrease client autonomy, feelings of belonging and community, and competence for recovery. What do you or your agency/program do to facilitate client autonomy and shared decision-making, feelings of belonging and community, and competence for recovery?

4.9. What are some other practices/policies your agency/program could put in place to...

- increase client autonomy?
- increase feelings of belonging and community?
- increase competence for recovery?

4.10. How does your agency/program integrate shared decision-making (which has shown to be a positive influence on client engagement and positive recovery outcomes); OR What are some choices that clients are allowed to make within your program?? What are some examples or strategies for how you or your agency/program delivers "patient-centered" care? Are there ways to improve upon the strategies you/your agency/program currently uses?

Chapter 5: Conclusion

Objective

Summary of major themes and thank you for the work you do.

Content Outline

1. Given research estimates 80% of people drop out of SUD programs between the first phone call and 30 days of the program, identifying and reducing barriers that can be addressed with limited or minimal targeted funding is important. Training all program staff who interact with clients, regardless of their role, in interpersonal skills such as active listening, demonstrating empathy, and a customer service approach and showing staff how these skills are valued is recommended, based on the findings of the four studies.

2. Program staff are the heart of SUD programs. Given this, supporting staff to carry out this important, meaningful, and challenging work is critical.

3. Stigma is mentioned as a huge barrier to client engagement and recovery. There is always more work to be done to counteract stigma.

4. The need to integrate abstinence-based and harm reduction strategies help clients engage in SUD programs and achieve long-term recovery. Multiple pathways to recovery exist, and acknowledging this will open up more opportunities for success.

5. Throughout the video, and research studies, it is clear that many clients have basic resource needs and those needs hinder client engagement. Programs also have limited resources. SUD cannot be effectively addressed as a social problem without also addressing housing insecurity, furthering education, employment readiness and opportunities, criminal justice system reforms, and building recovery supports outside of formal SUD programs. Policies need to be enacted to increase incentives and opportunities for collaboration across systems.

Chapter 5: Discussion Questions

5.1. Given research estimates 80% of people drop out of SUD programs between the first phone call and 30 days of the program, what would you say are the most important addressable barriers to client engagement in SUD programs that would not require additional considerable funding?

5.2. How important would you say staff are to the program and to client engagement? What does your agency/program do to support staff?

5.3. Stigma is mentioned as a substantial barrier to client engagement and recovery. What are your thoughts about the harm of stigma, why it still exists, and what can be done about it? Does stigma differ depending on the population (e.g., LGBTQ+, pregnant women, criminal justice involved)?

5.4. Discuss the importance of as abstinence-based and harm reduction strategies in helping clients engage in SUD programs. Do you sense tension between these strategies in your agency/program? If so, what are ways this can be resolved to strive for patient-centered care?

5.5. Throughout the video, and research studies, it is clear that many clients have basic resource needs and those needs hinder client engagement. Programs also have limited resources. What can programs do to help clients in this area?

5.6. What advice would you have for an individual or for a family member looking for a substance use disorder treatment program in Kentucky?

5.7. Identify 3-5 main barriers clients may experience in your agency/program. Make a plan for addressing each of those barriers and what it would take to address the barriers (e.g., additional training, quality control, funding).

5.8 What advice would you have for an individual or for a family member looking for a substance use disorder treatment program in Kentucky?

Overall Video Discussion Questions

If you are not interested in discussing each of the five chapters individually, you can use any of the questions in the chapters for discussion or use the questions posed below.

Discussion Questions

1. What are three reasons you think clients might not show up to their first appointment based on the phone call interaction?

2. What has your agency/program done, or what do you think your agency/program should do, during that first phone call to increase client engagement in your program?

3. Select three barriers or points made throughout the video that struck you as the most important. Why or what about these specific barriers did you find most important? What ideas do you have for addressing or how has your agency/program recently addressed these barriers?

4. What barriers, if any, did you think about but that were not mentioned in the video?

5. What are your top two recommendations for new agencies who intend to serve SUD clients?

6. Thinking more specifically about different populations and risk factors, what or how does your agency/program adapt to better meet these needs or risks?

7. Thinking more specifically about different populations, do you do anything differently with criminal justice referred clients compared to non-criminal justice referred clients throughout the program? Do you use any specific strategies to engage clients and are there different strategies for criminal justice involved clients versus those who are not involved in the criminal justice system?

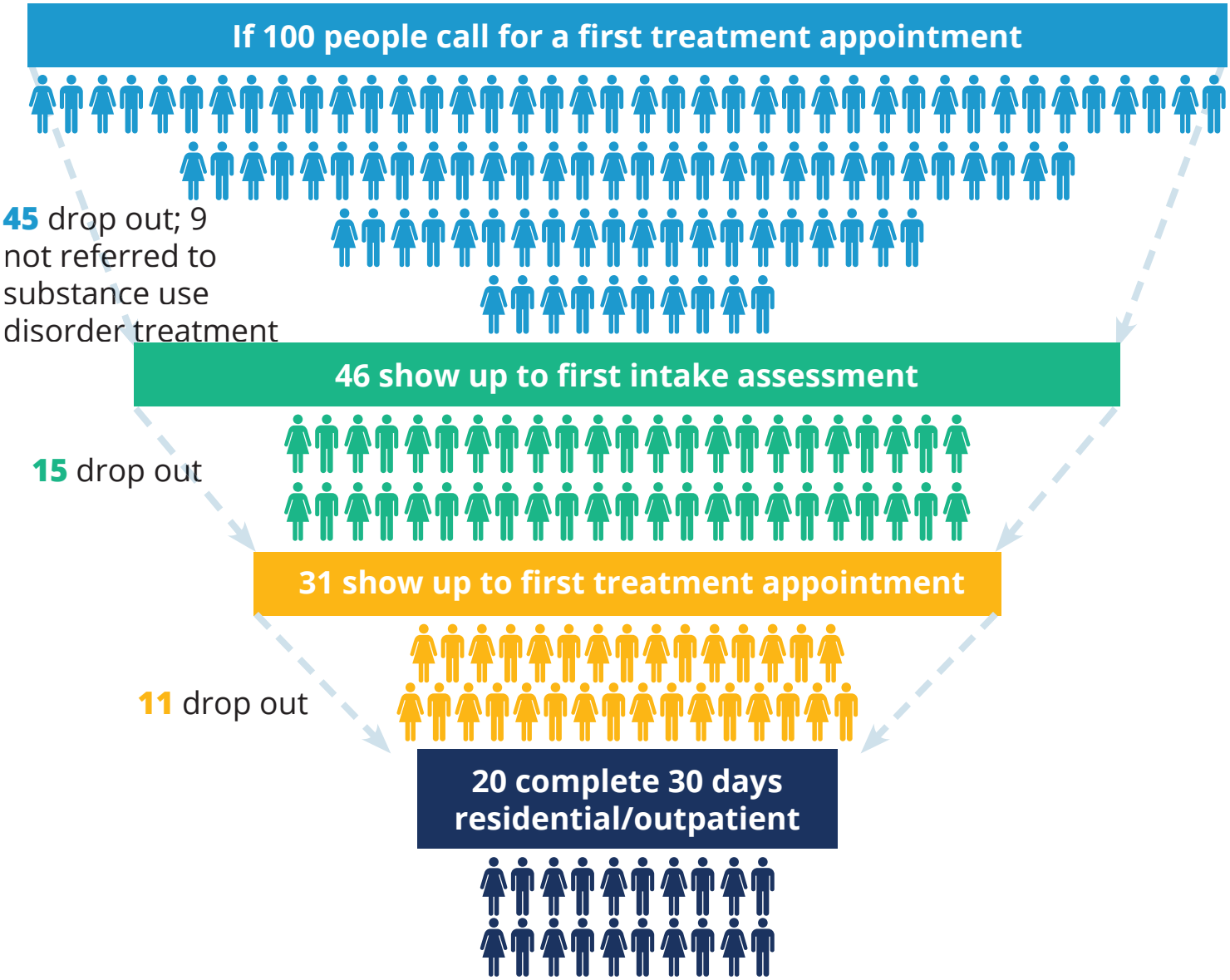
8. What advice do you have for engaging clients from the first phone call to 30-day residential or 30-day outpatient treatment?

9. Identify 3 - 5 main barriers clients may experience in your agency/program. Make a plan for addressing each of those barriers and what it would take to address the barriers (e.g., additional training, quality control, funding).

Appendix A: Infographic Handouts

1. Substance Use Disorder Program Attrition

One study found that close to **80%** of people drop out of a substance use disorder program before completing 30 days of treatment (residential and outpatient).[4]



[4] Loveland, D., & Driscoll, H. (2014). Examining attrition rates at one specialty addiction treatment provider in the United States: a case study using a retrospective chart review. *Substance Abuse Treatment, Prevention, and Policy, 9*(41), 1-13.

Logan, T., Cole, J., & Staton, M. (2024). *Strengthening Lifelines: Increasing Client Engagement and Retention in Substance Use Disorder Program Video Discussion Guide*. Lexington, KY: University of Kentucky, Center on Drug & Alcohol Research.

For more information, contact Dr. TK Logan at tk.logan@uky.edu.

2.1. Barriers and Opportunities During the First Phone Call for Services

The Importance of the First Phone Call

The first phone call for services is the **first step of program engagement**.

How that phone call goes **may influence whether the person shows up** in whether the person shows up.

A warm and caring interaction during the first call may encourage consumers to engage or re-engage more quickly.

Barriers

Personal Barriers

- Anxiety/fear *(Can I do it? Is it worth it?)*
- Feeling overwhelmed
- Past experiences with programs
- Resource constraints *(e.g., stable housing, transportation)*

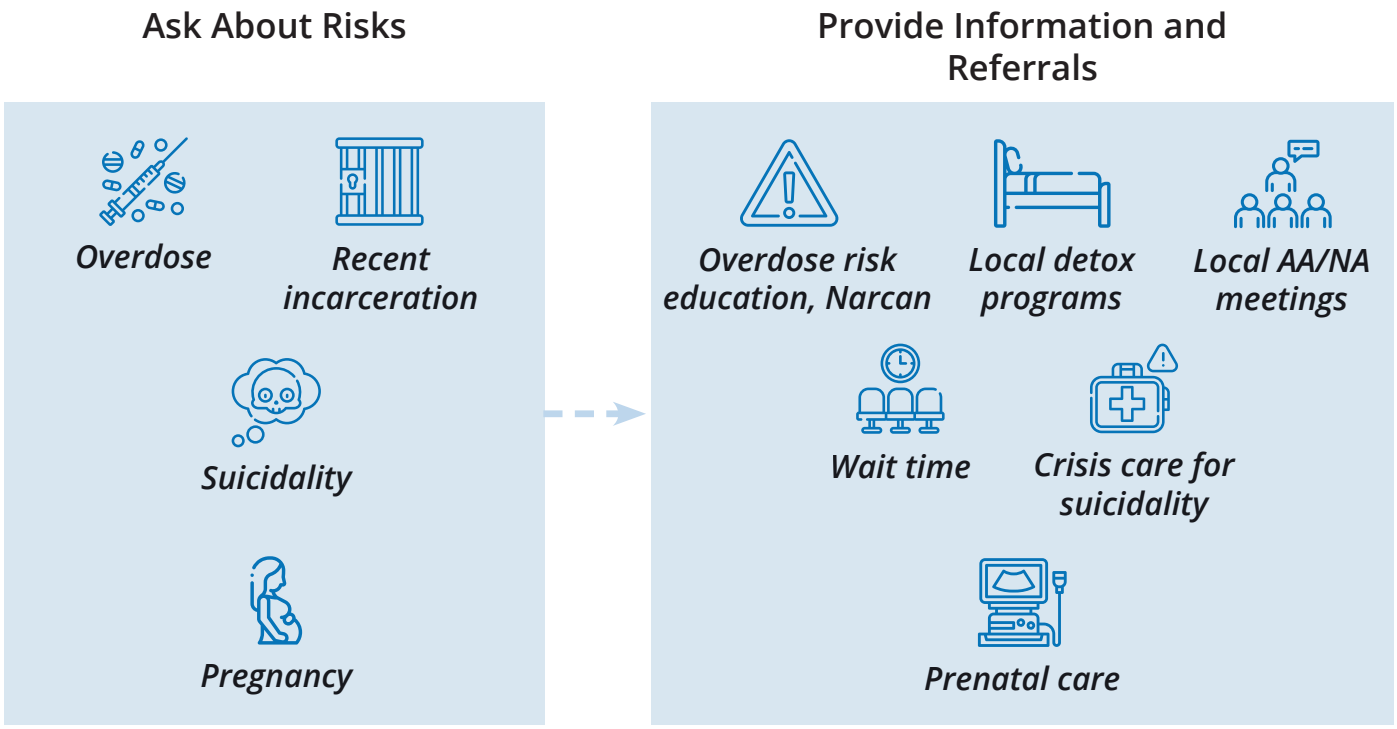
Program Barriers

- Lack of warmth and caring
- Stigmatizing language
- Long wait for intake appointment
- Lack of information about program location, parking
- Not knowing what to expect

Personal Motivation Can Be Impacted by:

- Program barriers
- Difficulty navigating life, justice system, and program constraints
- Limited personal resources *(e.g., having to always find a ride, unstable housing, childcare concerns)*

2.2. Opportunities During the First Phone Call for Services



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3.1. Intake Process

Overall Goals of the Intake and Assessment Process

Screen for risks and level of care

Begin building a therapeutic alliance

Listen for client concerns

Engagement in the program

Considerations

Burden of the intake process

Long wait time to receive treatment

Recommendations for program type vs client's preference and needs

Stigma and comfort with the program space, staff, and experience

Opportunities

Options for shared decision-making could start here

Harm reduction or other options to offer clients

Re-engagement strategies

Logan, T., Cole, J., & Staton, M. (2024). *Strengthening Lifelines: Increasing Client Engagement and Retention in Substance Use Disorder Program Video Discussion Guide*. Lexington, KY: University of Kentucky, Center on Drug & Alcohol Research.

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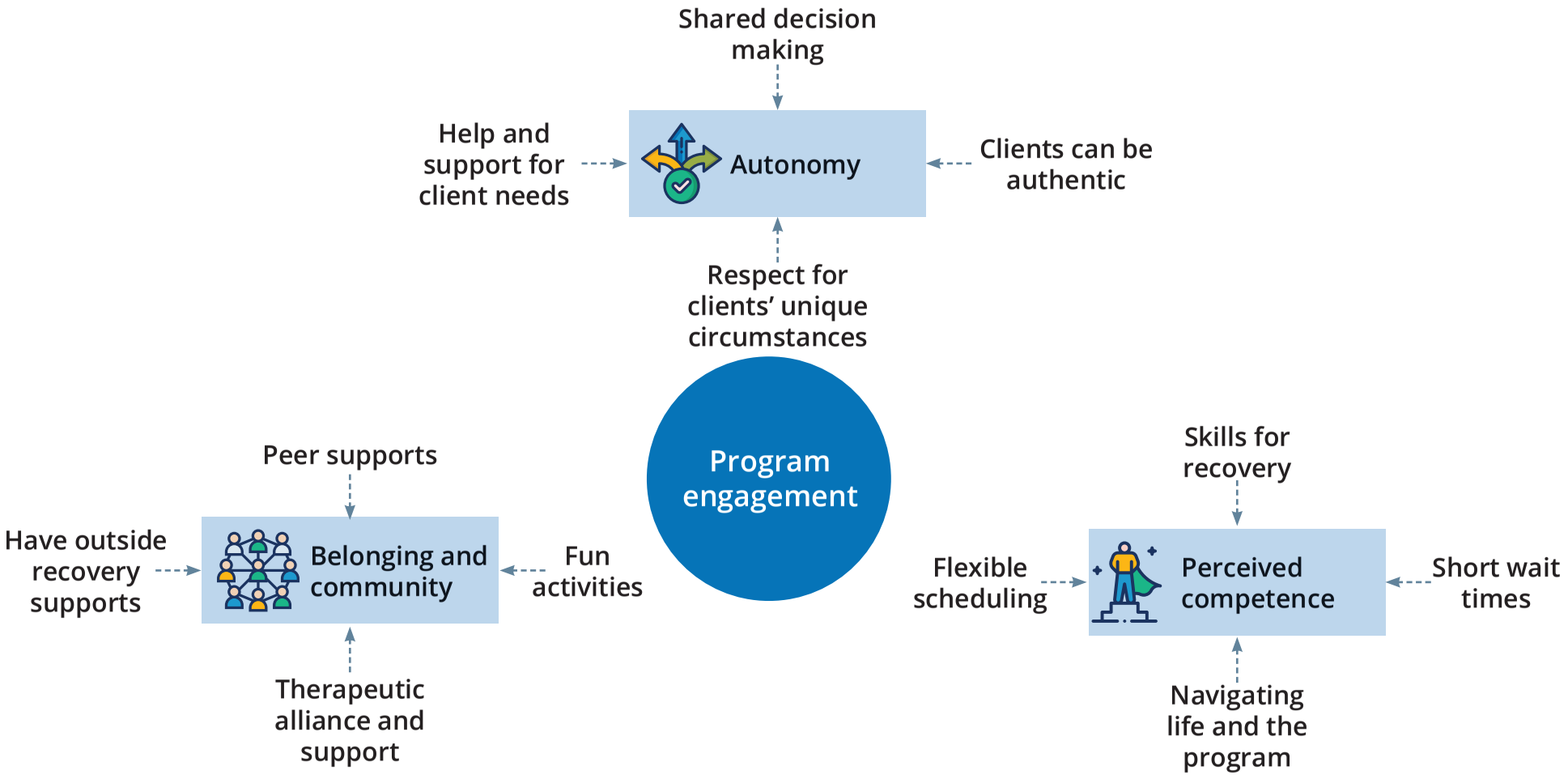
4.1. Program/Treatment Begins

Overall Goals

Client engagement to complete program or stay as long as needed

Build skills, autonomy, perceived competence, and support for recovery during and after leaving the program

Program Engagement Through Client-Centered Care



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4.2. Meeting Client Needs

Overall Goals

Client engagement to complete program or stay as long as needed

Build skills, autonomy, perceived competence, and support for recovery during and after leaving the program

	What keeps clients engaged?	What contributes to disengagement?
Wait times	Short wait times for program components	Long wait times for program components
Scheduling appointments	Flexibility of scheduling appointments	Inflexibility of appointments
Decisions	Shared decision making	Rigid rules
Treatment community	Belonging/Building community and support for recovery	Feeling isolated and alone
Hope and self-confidence	Peer support and therapeutic alliance give clients hope	Not feeling program staff believe in them and their ability to overcome
How program serves needs of clients	Meeting unique needs *(e.g., justice involved, trauma, minority)*	One-size-fits all
Skills and competence	Building skills and perceived competence through a. Successfully managing life and program requirements b. Building and maintaining personal resources	Difficult to focus on skills and feelings of incompetence a. Difficulty managing life and program requirements resulting in clients feeling like they can't succeed b. Unable to build resources or losing resources to participate in the program

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Appendix C: Summary of Research and Recommendations on Barriers to SUD programs in Kentucky

Summary of Research and Recommendations on Barriers to SUD programs in Kentucky

Results of four separate studies done in Kentucky in FY23 serve as an important interim step in identifying barriers to SUD program engagement and making recommendations to reducing some of those barriers as well as other steps that need to be taken to fully identify and document barriers to SUD program engagement (Cole, Logan, Tillson, Staton, & Scrivner,2023; Logan, Cole, Johnson, Scrivner, & Staton, 2023; Logan, Johnson, Cole, Scrivner, & Staton, 2023; Staton, Tillson, Logan, Scrivner, & Cole, 2023). The integrated conclusions and recommendations for the four research projects are organized in response to five main questions and presented in an overall report along with recommendations (Logan, Cole, Staton, & Scrivner, 2023).

Understanding barriers to SUD program engagement is an ongoing process and is part of the process of measuring program quality indicators. Additionally, targeted funding may be needed to reduce barriers and increase client engagement in SUD programs in general and specifically for individuals with unmet treatment needs.

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

Given the estimate that 45% of individuals do not show up for their first SUD appointment (Loveland & Driscoll, 2014), the first phone call may be one of the most important steps in engaging clients in SUD programs.

a. Consumers overcome several key personal barriers when making that first phone call for SUD programs including embarrassment, shame, fear, and anxiety (Logan, Cole, Johnson, Scrivner, & Staton, 2023; Staton, Tillson, Logan, Scrivner, & Cole, 2023). Standardizing the script for that first phone call and ensuring a warm and friendly tone is crucial, even if those consumers do not show up for that appointment. If consumers perceive negative, blaming and stigmatizing interactions during that first call, they may be less motivated to enter the program (Logan, Johnson, Cole, Scrivner, & Staton, 2023). The first phone call is the first step in engaging the client in the SUD program and even if they do not show up for the appointment, the hope is that they will re-engage in SUD programs, and re-engage quicker, if that first attempt at an appointment is positive.

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b. Having staff ask about scheduling preferences and providing information such as helping consumers know where to find the program, what to bring, and what to expect may be helpful in engaging consumers in SUD programs. Less than five percent of consumers (4.7%) who called a CMHC and two-thirds (66.7%) of consumers who called prenatal programs during business hours to make an

appointment were asked about travel distance or transportation needs (Logan, Johnson, Cole, Scrivner, & Staton, 2023). These small gestures may help facilitate motivation by making consumers more of a partner in their care.

c. Additionally, the first phone call could be used to educate consumers about SUD program approaches so the consumers are clearer about their expectations for what will happen and have more of a choice regarding what might be the best fit for them. Only 16.3% of consumers who called CMHCs and 41.7% of consumers who called prenatal programs during business hours were asked about their preferred program approach (Logan, Johnson, Cole, Scrivner, & Staton, 2023).

d. The first phone call could be used to conduct a very quick risk assessment, particularly for vulnerable individuals such as those with recent incarceration, overdose risk, suicidality risk, personal safety risk, and pregnancy. For example, individuals recently released from jail or prison may be at increased risk of overdose, have a variety of basic needs that are unmet, and have significant physical and mental health problems while individuals who are pregnant may not have seen a doctor. After the risk assessment, it may be helpful to provide some brief information, if consumers are interested, regarding overdose and Narcan, detox, AA/NA, prenatal services, and/or local domestic violence services as well as national hotlines may be important regardless of how long consumers have to wait for the appointment.

   This may be particularly important if consumers have to wait for an appointment. As one consumer interviewed summarized, "if you call and tell someone you need help, you need help right then and there, not 2-3 days down the line. If they don't take you right then, you might decide to go out and do it one more, and that be the end of it, kill yourself or something" (Staton, Tillson, Logan, Scrivner, & Cole, 2023).

   Overall results of the secret shopper study for the programs located at the CMHCs found that, during business hours, appointments were made at 88.4% of the programs with the average number of days to an appointment being nearly two weeks (Mean = 12.6 days, and median = 4.5 days, ranging from a same day appointment to an appointment 79 days later) approach (Logan, Johnson, Cole, Scrivner, & Staton, 2023). Over half of providers overall (58.0%) believed that clients are offered interim services while waiting for an appointment (Logan, Cole, Johnson, Scrivner, & Staton, 2023). However, the secret shopper results found that only 23.3% of consumers who spoke with CMHC program staff and 33.3% of consumers who spoke with prenatal program staff during business hours were offered any information or services to support recovery while waiting for an appointment, and most of the information provided, in the minority of cases it was provided, centered on informing consumers of the agency or program crisis line.

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

Three main themes emerged about what may increase the likelihood of recovery success including: (1) creating community; (2) opportunities for choices; and (3) identifying and monitoring staff barriers.

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

Consumers interviewed for the study had very positive things to say about working with peer support workers and recognized that they provide a unique understanding of the experience of addiction and pathways toward recovery (Staton, Tillson, Logan, Scrivner, & Cole, 2023). Program staff also talked about the significant benefit of having peer support workers as part of the program (Logan, Cole, Johnson, Scrivner, & Staton, 2023). Peer support workers may be particularly helpful for individuals involved in the criminal justice system as they can provided needed support but also hope in the form of a role model and as an important source of information for clients in terms of navigating both the SUD program and the criminal justice system (Bureau of Justice Assistance, 2022).

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Other factors can also play an important role in building community including staff belief in clients and giving them hope (McCallum et al., 2015; Staton, Tillson, Logan, Scrivner, & Cole, 2023), therapeutic alliance (DiClemente et al., 2016; Moyers & Miller, 2013; Ness et al., 2017), and engaging in fun activities to learn how to have fun while sober (McKay, 2017).

Allowing **opportunities for client choices** may help increase personal motivation (Shier & Turpin, 2017; Winsper et al., 2020). Consumers in the SUD program discussed feeling that the rules and regulations made them feel overwhelmed and constrained. Having flexibility, or even small opportunities for choice, to meet client needs (e.g., harm reduction strategies, having input and support to taper off of MOUD/MAT, flexibility of program hours, smoking cessation, program approach [i.e., MOUD/MAT, abstinence based]) can help clients feel more in control of their own well-being (Vakharia & Little, 2017). Also, having flexibility with regard to scheduling throughout the program so that clients can navigate their recovery and their personal life (and so their resources are not threatened) may be important.

Shared decision-making has been found, through research, to be a key factor in client engagement and satisfaction (Davidson & White, 2007; Ecklund et al., 2019; Friedrichs et al., 2018; Fredrichs, Spies, Harter, Buchholz, 2016; Joosten et al., 2011; Marchand et al., 2019; McCallum et al., 2015; Muthulingam et al., 2019).

Arguably the most valuable asset in SUD programs is the staff. Identifying, addressing, and monitoring **staff barriers** is crucial to maximizing staff tools, support, and time to

support their clients. Lack of support and resources for staff has been associated with barriers to client engagement (Ashford, Brown, & Curtis, 2018; Priester et al., 2016). It is particularly difficult for staff to do their jobs when they don't feel supported, which may make it harder for them to hide those feelings in order to support clients—termed emotional labor (Grandey & Sayer, 2019; Kim, Hur, Moon, & Jun, 2017).

Although the research on peer support workers has found mixed support in terms of SUD outcomes, a literature review found that individuals with complex needs in addition to substance use benefited from the support of peers across diverse types of interventions (Bassuk, Hanson, Greene, Richard, & Laudet, 2016). Yet, there were several concerns with peer support workers identified in the provider survey (Logan, Cole, Johnson, Scrivner, & Staton, 2023). In particular, boundary issues, lack of training and skills, and concern for peer support workers themselves being overwhelmed or even relapsing in the context of their employment were all mentioned as concerns. 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 to fill in gaps that may not be appropriate for their expertise and training. Considerable investments need to be put into training, education, supervision, and support for peer support persons, as well as with clinical staff about the role of peer support so that peer support workers are not overburdened, overwhelmed, or put into situations that are outside of their appropriate role.

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

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

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

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

Increased difficulty engaging in SUD programs is often related to adaptability barriers (Gainsbury, 2017; Steinka-Fry, Tanner-Smith, Dakof, & Henderson, 2017). Adaptability

barriers exist because SUD programs have not made the necessary changes to address the unique needs or vulnerabilities of clients.

Research suggests that several selected vulnerabilities can exacerbate SUDs and increase challenges to recovery including co-occurring: (1) mental health problems; (2) involvement in the criminal justice system; (3) trauma and victimization; (4) loneliness and isolation; and (5) basic resource needs. These vulnerability factors intersect with each other creating a variety of difficulties for the clients and the programs .

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Co-Occurring Mental Health Symptoms. Having a mental health problem is associated with also having a SUD while SUD recovery is associated with reductions in mental health symptoms (Jones et al., 2020). Higher levels of mental distress are associated with an increased risk for dropping out of SUD programs (Andersson, Steinsbekk, Walderhaug, Otterholt, & Nordfjaern, 2018). Additionally, adults with co-occurring mental health problems were arrested 12 times more often than adults with neither a mental health or a substance use problem and 6 times more often than those with a mental health problem alone (Wertheimer, 2023). Women with co-occurring substance use disorders and mental health problems were arrested 19 times more often than women with none of those issues, and they accounted for more than 1 in 5 of all women arrested.

Incarceration. Individuals with incarceration histories are often in need of SUD programs upon arrest and post-incarceration because of the high prevalence of SUDs among incarcerated adults (Tangney et al., 2016; Tsai & Gu, 2019). However, only a minority of adults with SUDs and incarceration histories engage in SUD programs (Tsai & Gu, 2019). Some research suggests individuals with incarceration histories with the highest risks and greater resource needs are least likely to complete SUD treatment (Olver, Stockdale, & Wormith, 2011).

Victimization. Post-Traumatic Stress Disorder (PTSD) and increased mental distress are both associated with victimization exposure and with SUD program drop out (Roberts, Roberts, Jones, & Bisson, 2015; Andersson et al., 2018). Although overall victimization rates between men and women who use substances do not vary much, type of perpetrator does (de Waal, Dekker, Kikkert, Kleinhesselink, & Goudriaan, 2017). For example, in Kentucky, between one-third and one-half of clients entering an SUD program through the Community Mental Health Centers (CMHC)s or the Kentucky Recovery Programs experienced firearm-related threats while about one-quarter of those experiences those firearm-related threats within the past year before entering the program (Logan, Cole, Schroeder, 2022; Logan & Cole, 2022).

Individuals victimized by partners and acquaintances are more likely to have experienced repeated assaults, to be women, and to experience trauma-related mental health symptoms (Logan & Cole, 2022; 2023a; 2023b; Logan, Cole, & Schroeder, 2022; Logan, Cole, & Walker, 2020; Logan, Walker, Jordan, & Leukefeld, 2006). Both men and women who use substances or who have been incarcerated have higher rates of interpersonal

victimization and trauma symptoms than individuals in the general population (Browne, Miller, & Maguin, 1999; Logan et al., 2006; Wolff, Huening, Shi, & Frueh, 2014). Also, individuals with recent victimization experiences have fewer resources when entering SUD programs than those without recent victimization experiences (Logan & Cole, 2022; 2023a; 2023b; Logan et al., 2022; Logan et al., 2020).

Loneliness. The U.S. Surgeon General recently released a report on the epidemic of loneliness and isolation in the U.S. (Murthy, 2023). Rates of loneliness and isolation have increased dramatically over time and are associated with negative physical and mental health consequences (Murthy, 2023). Loneliness and feelings of isolation have been associated with increases in substance use (Ingram et al, 2020) while positive recovery outcomes have been associated with increased social support (Binswanger et al., 2012; Brooks, Lopez, Rannucci, Krumlauf, & Wallen, 2017; Sliedrecht, Waart, Witkiewitz, & Rooozen, 2019). SUD programs help individuals increase social support and those supports enhance program engagement and positive outcomes, particularly for individuals with co-occurring SUD and trauma symptoms (Jarnecke et al., 2022; Kelly et al., 2010).

Basic Resource Needs. Successfully addressing addiction requires removing personal and environmental obstacles while establishing and maintaining an environment supportive of recovery, identifying and engaging with community-based services to support ongoing recovery needs, and increasing efficacy, hope, motivation, confidence and skills needed to initiate and maintain the difficult and prolonged work of recovery (Davidson et al., 2010). When an individual is struggling to meet basic needs such as shelter, food, safety, and experiencing disconnection from friends and family, they may have greater difficulty with the tasks needed to address addiction (Beaulieu et al., 2023; Browne et al., 2016; Lee et al., 2017; Logan et al., 2020; Logan & Cole, 2023; Logan, McLouth, & Cole, 2022; Manuel et al., 2017; Padgett et al., 2016; Substance Abuse & Mental Health Services Administration, 2016; Tripodi et al., 2023). Vulnerable substance abusers, such as those transitioning out of jails or prisons, may have more limited internal and external recovery resources and these resources are thought to play an important role in SUD program initiation, maintenance, and longer-term recovery (Chen, 2018; Kahn et al., 2019; Priester et al., 2016). At the same time, clients with significant resource deficits can overwhelm traditional SUD treatment programs because program resources are often limited, and specialized SUD services have become even more limited in recent years (Padgett et al., 2016; Priester et al., 2016; Su, 2017). Resource deficits, along with polysubstance abuse, can also make it difficult for these clients to participate in medication assisted treatment (Walker, Logan, Chipley, & Miller 2018). Although current evidence indicates that the uptake of opioid agonist therapy can be effective for opioid use disorder (Connery, 2015), the evidence is less clear for individuals with polysubstance use and for those with significant resource deficits.

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

Improvements to program quality are often informed by program performance indicators as discussed in the Performance Indicator Project (Cole, Logan, Tillson, Staton, & Scrivner, 2023). Performance indicators provide two main kinds of information: (1) feedback in order for providers to improve care and assess progress toward agency/program goals; and (2) information on how providers are delivering services to client populations and communities (i.e., program accountability).

Kentucky's multi-year client-level outcome evaluations are a valuable resource for understanding and informing publicly-funded SUD treatment in the state.

Many states' performance indicator efforts focus on access and process factors of SUD treatment, with less attention to client outcomes, because of the cost, lack of human resources, and difficulty of carrying out systematic evaluations (Harris et al., 2009). Thus, Kentucky's multi-year client-level outcome evaluations are a valuable resource for understanding and informing publicly-funded SUD treatment in the state. The client-level outcomes and clients' perceptions of care collected in the three outcome evaluations (KTOS, RCOS, CJKTOS) map well onto the outcomes considered important in the performance measurement literature as outlined in the Performance Indicators Project Report: return to substance use, symptoms, functioning, recovery supports, well-being, and client perceptions of care (Cole, Logan, White, & Scrivner, 2023a; 2023b; Staton & Tillson, 2024). These Kentucky studies also provide feedback regarding specific aspects of the SUD program that worked or did not work well for clients. The findings from the outcome evaluations are shared with the provider agencies and DBHDID, as well as posted on UKCDAR's website, which can be accessed by the public.

The majority of providers indicated their agencies are tracking a lot of information about program performance; however, the information is not transparent or shared widely in a way that staff or consumers can use (Logan, Cole, Johnson, Scrivner, & Staton, 2023). Transparency in performance is crucial to educating consumers about SUD programs as well as others who are investing in these programs. The performance indicators must be feasible, reliably and systematically collected, and collected in a way that can be reported without burdensome digging through electronic health records. Key stakeholders in collaboration (including consumers, providers, and DBHDID) are in the best position to select program performance indicators based on their priorities.

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

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

treatment services by key demographic information including age, race/ethnicity, pregnant, non-English-speaking, veterans, etc.);
3. process indicators (such as proportion of potential clients who show up to first appointment, wait times, proportion of clients who receive transportation vouchers/ assistance, proportion of clients who end treatment by completion or transfer);
4. client perceptions of care indicators in addition to the data already gathered in the outcome evaluations (collecting client feedback in a systematic and anonymous manner during treatment and at program exit); and
5. outcomes collected by SUD programs as clients exit (such as percent of clients with no arrests since admission, percent of clients who are abstinent at program exit, percent of clients who have stable housing at program exit, percent of clients who are employed at program exit).

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

The response to this question may vary depending on who is answering (i.e., consumers, current or former clients, staff); thus, it is important to include multiple perspectives when fully assessing barriers. Even so, several key barriers that were identified in both the staff and the consumer surveys will be discussed here: (1) client resource barriers, (2) program and staff quality barriers, and (3) policies regarding sanctions and termination due to relapse (Logan, Staton, Tillson, Logan, Scrivner, & Cole, 2023).

Before discussing resource and program quality barriers, it is important to note that client motivation was identified as a barrier by over half of staff for program entry and retention (Logan, Cole, Johnson, Scrivner, & Staton, 2023). It was also noted as a barrier to SUD program engagement by consumers (Staton, Tillson, Logan, Scrivner, & Cole, 2023).

Client motivation is essential for recovery and program engagement. However, the cause of lowered motivation can be multilayered and reducing program and resource barriers may increase client motivation for program engagement and recovery. Program and resource barriers may undermine clients' feelings of **autonomy, competence and belonging**, which are hypothesized to be important for motivation and overall well-being (Ryan & Deci, 2000). These three factors are often implicit or explicitly included in frameworks for working with SUD clients including client centered care, recovery-oriented care, and trauma-informed care (Davidson & White, 2007; DiClemente et al., 2016; Ecklund et al., 2019; Marchand et al., 2019; McCallum, et al., 2015; Simon & Snow, 2020; Shier & Turpin, 2017; Winsper, et al., 2020).

Client motivation is essential for recovery and program engagement. However, the cause of lowered motivation can be multilayered and reducing program and resource barriers may increase client motivation for program engagement and recovery.

Clients' motivation to work toward recovery and participate in SUD programs can be undermined by several key factors including resource deprivation, lack of support for recovery, and program-level barriers. When an individual is struggling to meet basic needs

such as shelter, food, safety, and experiencing disconnection from friends and family, they may have greater difficulty with the tasks needed to address addiction. Vulnerable substance abusers, such as those transitioning out of jails or prisons, may have more limited internal and external recovery resources and these resources are thought to play an important role in SUD program initiation, maintenance, and longer-term recovery. At the same time, clients with significant resource deficits can overwhelm traditional SUD treatment programs because program resources are often limited.

Also, clients' perceptions of judgment and stigma from program staff and from the community may undermine feelings of competence and belonging and have been shown to have a negative impact on client engagement in SUD programs and recovery (Ashford et al., 2019; Browne et al., 2015; Cernasev et al., 2021; Fiddian-Green et al., 2022; Hutchinson et al., 2023; Simon et al., 2020; . Staff members may not be aware that some of their responses and interactions with clients may be interpreted by clients as judgmental or negative. Clients must also feel supported and encouraged by program staff that they can and are able to be successful in the program and in recovery, particularly when they have setbacks. One of the challenging aspects of working with individuals with SUD is that, particularly in the early stages of recovery from SUD, denial and minimizing the negative impacts of SUD on one's life are common.

Client resource barriers interfere with their ability to engage in SUD programs. Behavioral changes are difficult to take on for everyone, but people in recovery are often working on changing their behavior while also coping with mental health problems, trauma, and legal issues, all while balancing program appointments, requirements, and paperwork in the face of maintaining their "regular" life responsibilities (e.g., employment, housing, children, and other family responsibilities). Compounding these issues with negativity and stigma from others, clients can become overwhelmed and frustrated. As an example, Recovery Kentucky clients tend to have significant economic vulnerabilities, but because the program provides for many basic needs (e.g., housing, food, social support), most clients who enter Phase 1 of the program complete Phase 1 (85.0%) and they have lower relapse rates (around 15%) than some other programs (Logan et al., 2020; 2022). It is important to note that clients also stay in the program between 6 and 7.5 months and longer program length is also associated with better outcomes (Logan et al., 2020; 2022). Thus, support for basic resources may be crucial to successful program engagement and sustained recovery.

Another barrier noted throughout the staff and consumer surveys was related to **program and staff quality**, although fewer program staff mentioned these barriers compared to consumers (Logan, Cole, Johnson, Scrivner, & Staton, 2023; Staton, Tillson, Logan, Scrivner, & Cole, 2023). Consumers mentioned experiences of being treated like a number, feeling that they were only there for program financial reasons, or being exploited in other ways. Additionally, over half of both staff and consumers indicated that clients who do not take the program seriously are a barrier for program engagement for other clients. A better understanding of how some clients may act in ways that are disruptive to their peers is needed to target changes in program policies and strategies.

When clients relapse while in the program, it can endanger the recovery of other clients

and make other clients feel they are not taking the program seriously. For these reasons, some programs heavily **sanction or terminate** these clients when they relapse. In other cases, it is not due to the SUD program policies but rather the criminal justice system that has mandated the client's participation in SUD program with specific rules and procedures regarding relapses. Staff mentioned this as a significant barrier to client engagement in SUD programs (Logan, Cole, Johnson, Scrivner, & Staton, 2023).

Recommendations

This section highlights nine main recommendations identified from the results of the four studies (Logan, Cole, Staton, & Scrivner, 2023).

1. Facilitate program engagement starting at the first call by standardizing protocols and educating staff on the importance of that first phone call in engaging clients in the SUD program as well as helping those who do not show up for that appointment re-engage in SUD programs later. Peer supports may also be helpful in engaging consumers before their first appointment and through their first few appointments.

2. Identify all personal, program, and systemic barriers to SUD programs regularly. It is estimated that around 80% of consumers disengage from SUD program before clients complete 30 days of the program. Barriers that occur after clients show up to their first appointment to the first 30 days of the program were not identified within the four recent studies. One option, to more fully document all barriers, might be to use key informants as mock consumers to "walk-through" and map entry into the program to identify barriers at each step in the process.

3. Capitalize on the science of engagement and motivation by encouraging client choices where possible (autonomy), increasing client feelings of competence (e.g., skills building, helping with basic resources), and helping build community and supports for clients. These three factors may be particularly salient for criminal justice-involved clients who are often mandated to treatment programs. Obtaining feedback from clients about resource needs and program efforts to support those needs may also be helpful. Clients must also feel supported and encouraged by program staff that they can be successful in the program and in recovery, particularly when they have setbacks.

4. Criminal justice-involved clients may have unique barriers to SUD program engagement due to being mandated to SUD programs (with little choice of treatment approach or location), having a higher risk of overdose, and having limited personal resources. Additionally, coordinating criminal justice requirements with SUD program requirements can be difficult for both clients and program staff. Sanctions for relapse may be especially punishing for these clients. Even so, engaging these clients in SUD programs can significantly reduce societal costs as criminal behavior is reduced after SUD treatment. A recent review of the economic benefits of SUD treatment found that one of the largest categories of cost savings from SUD treatment include reductions in criminal activity or criminal justice costs (Fardone et al., 2023).

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

6. Peer support workers can facilitate SUD program engagement. However, efforts are needed to ensure peer support workers have the needed training, education, supervision, and support, as well as training with clinical staff about the role of peer support so that peer support workers are not overburdened, overwhelmed, or put into situations that are outside of their appropriate role.

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

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

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