Moving Towards a More Responsive Substance Use Disorder Continuum of Care:
A Comprehensive Community Needs Assessment of the Kansas City Metropolitan Area

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CHAPTER 1. EXECUTIVE SUMMARY

Introduction

We approached this community needs assessment based on the assumption that every service sector has both strengths to build upon and gaps that contribute to daily frustrations. We spent a good part of a year studying the ins and outs of facilities providing services for populations at risk of, in need of treatment for, or in recovery from a substance use disorder (SUD). In this process, we encountered a multitude of providers who conveyed an equal mix of dedication to their field, passion for helping individuals and families struggling with substance misuse, and worry about the limited time and resources available to tackle this immense social challenge. We hope that the readers of this report view it as a starting point rather than an ending point. It can serve as a resource to leverage for funding or as a place to begin problem solving about how one can build upon the existing strengths to address the identified service gaps.

Assessing the Addiction Continuum of Care’s Ability to Respond to an Opioid Epidemic

An estimated 20.1 million individuals ages 12 years or older were in need of services to address substance use disorders in the United States; approximately 10% of these individuals were identified as having an opioid use disorder (Substance Abuse and Mental Health Services Administration, 2017). Drug overdose death rates have risen by 10% per year from 1999 to 2016 (Hedegaard, Warner, & Minino, 2017). Figure 1.1 is a graph created by the National Institute on Drug Abuse (NIDA) to show the increase in drug overdose deaths involving opioids over time (National Institute on Drug Abuse, 2018). These trends in opioid-related overdoses and deaths have become a growing concern across the United States. More locally, an estimated 4.03% of Kansas residents and 4.21% of Missouri residents aged 12 or older engaged in nonmedical use of prescription pain relievers between 2012 to 2014 (Lipari, Van Horn, Hughes, & Williams, 2017). The 2016 drug overdose death rate in Kansas was statistically lower than the U.S. rate of 19.8 per 100,000 population; however, the death rate in Missouri was statically higher than the U.S. rate (Hedegaard, Warner, & Minino, 2017).

In response to these concerning trends and a lack of “hard” data to support provider observations of local service needs, the Kansas City Opioid Treatment Work Group conducted a brief gap analysis in 2016 to identify service sector needs for clients at-risk, in need of treatment, or in recovery from opioid-related use disorders. This initial scan of the service sector lead to the call for a more comprehensive community needs assessment of the SUD continuum of care in the Kansas City metropolitan area. The goal was to identify service gaps, with special attention to opioid-related services, which providers could strategically target to better prepare for impending substance-related needs of the community.
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Table 1.1: National Overdose Deaths – Number of Deaths Involving Opioids (NIDA, 2018)

![National Overdose Deaths](image)

Methodology

This report captures a point in time snapshot of the SUD service sector in the Kansas City metropolitan area between Fall 2017 to Spring 2018. We defined the SUD continuum of care broadly to include all services that provide support to individuals at risk of, in need of treatment for, or in recovery from a SUD related to alcohol and/or other drugs. We collected data on crises hotlines, advocacy organization headquarters, prevention services, screening/assessment services, medication-assisted treatment (MAT) providers, detox services, intervention specialists, substance use disorder (SUD) treatment services (i.e., all levels of care from inpatient to traditional outpatient), recovery support/housing, mutual aid groups, and supportive case management services (if attached to SUD treatment).

To create a comprehensive Census of agencies providing services along the addiction continuum of care, we triangulated information from over 20 well-established referral listings in the Kansas City metropolitan area. To fill potential gaps within these resource listings, the research team also met with local representative of government agencies and actively participated in local task force/coalition meetings. Using these methods, the research team aimed to obtain a census of agencies and unique facility locations that were located within the 10 county Mid-American Regional Council (MARC) region that cover the Kansas City Area: Clay (MO), Ray (MO), Jackson (MO), Lafayette (MO), Johnson (MO), Cass (MO), Platte (MO), Leavenworth (KS), Wyandotte (KS), and Johnson (KS). We then de-duplicated the list by name and address location resulting in a final listing of 216 agencies comprising 410 facility locations that we identified as providing services along the SUD continuum of care. Chapter 2 provides a detailed description of the methods used to obtain the data used for this report.
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Highlights from the Report

While a thorough policy analysis was outside the scope of this project, we provide a brief summary of common stakeholder concerns regarding the challenges of working in a metropolitan area bisected by the Kansas-Missouri state line in Chapter 3. Key themes addressed by stakeholders include the tendency for providers to “stick to one side of the state line”, how difference in funding across states dictates services, how differences in licensing for addiction counselors shapes the workforce, and the negative consequences of differences in prescription drug monitoring programs.

Chapter 4 continues the exploration of context by analyzing population indicators for SUD risk and treatment needs. Not surprisingly, we identified Jackson County, MO with its dense, urban environment as a high risk/need context across all population indicators. In addition, increases in the drug-related death rates in Jackson County, MO in recent years indicates a growing need for services. Indicators for Ray County, MO demonstrated higher levels of poverty, drug supply, and substance-related deaths than surrounding counties, suggesting a high need for services in this area. In this chapter, we also explore county-specific needs. For example, Johnson County, MO demonstrated a high percentage of adolescent prescription drug use, making it a prime target for prevention efforts that focus on educating youth about the harms of these behaviors and on mitigating harms related to prescription drug misuse.

Chapter 5 provides an overview of our findings for the SUD continuum of care as a whole. The SUD continuum of care is strong but not strong enough to curb rising drug-related overdoses and deaths. We observed a mismatch between risk and service locations for rural counties: The substance-related risks are high in many rural counties, yet service density in these areas is low. In addition, the relative availability of services (and associated funding sources) for low-income populations is insufficient to address service demand. We also observed that the SUD continuum of care lacks the capacity to serve non-English speaking populations. Finally, the availability of services specializing in addressing the needs of high-risk, vulnerable populations, such as pregnant and post-partum women (PPW) or individuals identifying as LGBTQIA+, is relatively low.

Chapter 6 details the service sectors’ ability to address opioid-specific treatment needs. We observed that first responders were seeing an increase in opioid-related overdoses, but treatment providers reported not seeing these individuals entering treatment at similar rates. There appears to be a need to strengthen collaborations between first responders and treatment providers to better identify individuals most in need for opioid-specific treatments. Along these lines, we observed a need to increase the continuum of care’s capacity to identify and engage individuals most at risk for opioid-related overdose and deaths and to support the families of these individuals. Finally, facilities willing to accept clients using MATs was proportionally lower among outpatient and recovery services. We argue that it is essential to help build capacity among outpatient and recovery services to address the needs of clients with opioid-related disorders, given individuals are often as the high risk for opioid-related overdoses and deaths if they relapse after treatment and an associated period of abstinence (World Health Organization, 2014).

Chapter 7 highlights some key findings for services by level of care. For utility, this section summarized key findings for each level of care within two pages, allowing users of this report to easily digest findings and translate the information into a 1-page handout for dissemination. One of many findings indicated a need to...
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Invest in developing more screening, brief intervention, and referral to treatment (SBIRT) programs and other primary prevention strategies to minimize substance-related harms, particularly for vulnerable populations like substance-using parents with children. In addition, we observed significant service gaps (defined by wait time for service) for individuals as they level down from more to less intensive services: (a) medical detoxification or inpatient to residential care and (b) inpatient or residential care to recovery housing. Facilities providing both residential care and recovery housing reported higher demand than available services, particularly for specific populations such as women with children or clients using medication assisted treatment for their opioid use disorder.

Top Five Recommendations

Chapter 8 provides a convenient summary of the strengths, gaps, and recommendations identified throughout the report. We discuss the key areas of concern that were salient across the community needs assessment. We suggest several recommendation for each of these concerns and highlight the top five recommendations here:

- **Establish partnerships to make a more responsive SUD continuum of care.** We recommend establishing partnerships between first responders and service providers to enhance opportunities to engage individuals into treatment. In addition, we argue that there is a need to establish better partnerships between agencies or to develop more services that specifically address the service gaps that arise from extensive waitlists for clients as they step down to less intensive levels of care (e.g., detox/inpatient → residential facilities; residential facilities → recovery housing). Finally, we suggest collaborating with natural helpers within communities of color, low-income communities, and other communities to facilitate engaging individuals into formal treatment services.

- **Invest in services, such as primary prevention and recovery supports, that keep individuals healthy and living safely in the community.** If we want to address drug-related deaths, we have to think proactively. It is essential to invest in initiatives that helps to prevents individuals from engaging in non-medical use of prescription drugs, such as interstate prescription drug monitoring programs or primary prevention programming with high-risk populations. In addition, it is equally important to invest in recovery promotion that helps individuals transition into long-term recovery and reduce likelihood of relapse.

- **Promote education about, access to, and use of NARCAN (naloxone HCl) and other medication assisted treatment for opioid use disorder.** Several of the providers and mutual aid groups reported not accepting or having reservations about accepting clients using MATs due to their skepticism around use of MATs, prior negative experiences with clients using methadone or buprenorphine, and/or use of 12-step models that did not tolerate any narcotics use. We recommend the need to continue and expand education about, access to, and use of medications that help to prevent overdose, to detox, or to manage recovery. We also strongly encourage that these trainings focus on the evidence that medication only approaches are not the same as medication assisted treatment that is defined by a more holistic approach to treatment.
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- **Build explicit supports for less intensive levels of care to address the needs of clients with opioid use disorder and/or using medication assisted treatment (MAT).** Recent initiatives have focused on increasing accessibility of MATs to the public, but we observed an unintended side effect of these initiatives related to less intensive services, such as outpatient or recovery housing. These services are proportionally less open to accepting clients using MATs. That being said, less intensive services linked to more intensive services and/or psychiatric services were more likely to accept clients using MATs because they felt they had adequate supports to address the needs of clients with opioid use disorders and using MATs. We highly recommend developing initiatives to increase availability and access to services for these clients across the SUD continuum of care, specifically with helping less intensive services build infrastructures that better support them in addressing opioid-specific client needs.

- **Think creatively to address on-going concerns.** Several of the identified gaps are not new to the SUD continuum of care—availability of services for low-income populations, need for a diverse workforce, or insufficient service capacity within low-density geographic areas. We encourage stakeholders to begin developing creative strategies to address these “usual suspects”. For example, transplanting urban service models within rural counties will not likely work, but some providers are moving towards leaning on alternative strategies such as telemedicine, telephone-or text-based recovery management, peer navigators who can travel to the individual, or online formats of mutual aid groups to increase accessibility.

If you have any questions about the community needs assessment, information in this report, or assistance in how to think about using this data to take the next steps, please contact Nancy Jo Kepple, Ph.D., M.S.W. at njkepple@ku.edu or (785) 864-0147.
CHAPTER 2. METHODOLOGY

Purpose of the Study

We aimed to capture a point-in-time assessment of the substance use disorder (SUD) service sector in the Kansas City metropolitan area between Fall 2017 to Spring 2018. We defined the substance use disorder continuum of care broadly to include all services that provided support to individuals at risk of substance misuse, actively misusing alcohol and/or other drugs, or in recovery from a SUD. We collected data from crises hotlines, advocacy organization headquarters, prevention services, screening/assessment services, medication-assisted treatment (MAT) providers, detox services, intervention specialists, SUD treatment services (i.e., all levels of care from inpatient to traditional outpatient), recovery support/housing, mutual aid groups, and supportive case management services (if attached to SUD treatment).

We used this information to update a central crisis referral hotline (816-361-5900) and associated online resource guide (https://www.firstcallkc.org/resources) hosted by First Call Alcohol/Drug Prevention & Recovery. We also followed a systematic approach to conduct a rigorous community needs assessment, allowing us to identify specific service strengths and gaps. In addition to questions about general services, we asked targeted questions about opioid-specific treatment services. This information helped us understand how the Kansas City metropolitan service sector could further develop their SUD continuum of care in ways that adequately prepared providers to address impending opioid-related prevention, treatment, and recovery needs.

Creating a Census of Existing Agencies & Facilities along the Continuum of Care

We triangulated information from existing referral listings to create a comprehensive census of agencies or organizations providing services along the SUD continuum of care. As a starting point, we obtained well-established referral listings in the Kansas City Metropolitan area from United Way 211, My Resource Connection (Johnson County), Kansas Department of Aging and Disability Services (KDADS) Treatment Facility Summary, Missouri Department of Mental Health (DMH) Listings of Eligible Providers, and First Call Alcohol/Drug Prevention & Recovery. In addition, we pulled listings from the following online directories: Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator, Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, Celebrate Recovery, Oxford Houses, University of Kansas Medical Center (KUMC) Resource List, National Directory of Drug and Alcohol Abuse Treatment Listing, Addicted.org, DrugRehab.org, Recovery.org, FreeAddictionCenters.org, and Psychology Today.

To fill potential gaps within these directories, we also met with local representative of government agencies (e.g., Kansas Department of Aging & Disability Services, Missouri Department of Mental Health, and SAMHSA) and actively participated in local task force/coalition meetings (e.g., Opioid Task Force, KC Trauma Matters, KC Homelessness Coalition, KC Substance Abuse Treatment & Recovery Support Coalition).
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Using these methods, we aspired to obtain a census of agencies and unique facility locations that were located within the 10 county Mid-American Regional Council (MARC) region that cover the Kansas City Area. These include 7 counties in Missouri-side (i.e., Clay, Ray, Jackson, Lafayette, Johnson, Cass, and Platte) and 3 counties on the Kansas-side (i.e., Leavenworth, Wyandotte, and Johnson) of the Kansas City Metropolitan area. This list was then de-duplicated by name and address location. We then verified that each location on our list was active and providing services to clients between September 2017 and March 2018. These procedures resulted in a verified listing of 216 agencies comprising 410 facility locations.

Data Collection Procedures to Determine Existing Substance-related Services

We followed procedures to make contact with all agencies in the census of agencies and facility locations. In the end, we used four sources of information with parallel structures to determine existing substance-related services by facility location. Triangulation was required given no one data source captured our expanded definition of continuum of care.

Prevention & Treatment Services

The final master database includes information that was integrated from the substance use services survey, web scrape, follow-up telephone interviews, and SAMHSA locator. This was possible given all sources were based upon the 2016 NSSATS survey structure, which allowed us to systematically collect information in the same way across multiple modalities. When information was inconsistently reported, researchers prioritized data based on credibility of source, rigor of data collection, and most recent date of collection. The findings in this report related to existing services are based upon the 410 facility locations (76.8% of total identified facilities from combined and deduplicated referral listings) that we verified using these procedures as currently in operation and serving clients. Of the final list of facilities, 166 (40.4%) were verified using 3 or more of the following sources; 230 (56.1%) were verified using 2 of the following sources; and 14 (3.4%) were verified using 1 of the following sources:

1. **Substance Use Services Survey.** This study modified the 2016 version of the National Survey of Substance Abuse Treatment Services (NSSATS) to ask agencies about their approach to treating clients with Opioid-related concerns and services being provided at each facility location. The survey was composed of the following areas: All agencies were contacted to ask if they would like to participate in a 30-minute survey via a web-based survey, telephone interview, or in-person interview. A total of 85 (20.7%) out of the 410 facilities that were verified as providing services along the continuum of care completed the full survey.

2. **Web Scrape & Follow-up Telephone Interview.** For agencies that did not complete the full survey, the research team used an abbreviated version of the survey to systematically pull information from public web sites for each agency (when available). All these agencies were then contacted via telephone to: (a) verify information pulled from the web and (b) asked about service details using a short format of the SUD Services Survey. Approximately 60% percent of facilities (244 out of the 410 verified facilities) were contacted using this approach.
(3) **SAMHSA Locator.** To verify or supplement the information obtained from the prior procedures, the research team also used public information from the SAMHSA NSSATS locator providing detail on facility locations and associated services reported on the most recent version of the NSSATS. (The locator website noted that the data was updated during January 2017). This provided information on 127 out of the 410 (31.0%) verified facilities.

(4) **State Summaries of Eligible SUD Services by Location.** To verify or supplement the information obtained from the prior procedures, the research team also used public information from the Kansas Department of Aging and Disabilities (KDADS) and the Missouri Department of Mental Health (MODMH). These listings identified eligible services by agency, facility location, funding source, and population served. We identified 171 facilities (41.7% of verified facilities) through state listings.

**Mutual Aid Groups**

We collected listings of 371 registered mutual aid groups and their meeting locations within the 10-county region for the following organizations: Alcoholics Anonymous, Narcotics Anonymous, Marijuana Anonymous, Cocaine Anonymous, Crystal Meth Anonymous, Dual Recovery Anonymous, Celebrate Recovery, SMART Recovery, Moderation Management, AlAnon, Alateen, Adult Children of Alcoholics, NarAnon, Narateen, DualAnon, and other general family support reports reported within our survey process.

**Key Informant Interviews**

We met with key informants that held leadership positions within local, state, and/or federal government agencies that were responsible for substance-related services. We also reached out to leaders within the field and leaders of agencies conducting innovative practices, who we identified through local media outlets, coalition meetings, and discussions with other key informants. Our goal was to obtain a representation of viewpoints along the continuum of care that captured: (1) government, private, non-profit, and faith-based organizational perspectives; (2) representatives from both Kansas and Missouri service sectors; and (3) range of services from prevention to service linkages to treatment to recovery supports. From September 2017 to March 2018, we conducted 30 key informant interviews.

**Data Collection for Population Indicators of Substance-Related Risk & Service Needs**

Understanding the drug environment is complex because we often must depend on proxy measures for risk, use, misuse, and drug-related overdoses or deaths. We drew from several sources (described below) to identify relevant population indicators for substance-related risk and service needs.

**American Community Survey Census Estimates.** We used 5-year Census estimates (2011-2016) from the American Community Survey at two geographic resolutions: (1) County and (2) Zip Code Tabulation Area (ZCTA; US Census Bureau, 2017).

**CDC Wonder.** We obtained five-year (2012-2016) crude death rate for alcohol-related deaths, drug-related deaths, and substance-related deaths per 100,000 population by county (Center for Disease Control and Prevention, 2018). The low number of drug-related deaths resulted in suppression of several death rates at the county-level. As a result, we only report substance-related death rates (i.e., due to alcohol or other drugs).
Community CareLink Referral Data. Community CareLink is a software that facilitates referrals between social service agencies. These counts represent the number of individuals seeking substance-related services through Community CareLink; it also includes zip code of origin (as identified by the referring agency) for clients being referred between January 1, 2017 to March 15, 2018. Please note that this data only represents the agencies actively involved within Community CareLink, suggesting the data is most reliable for Jackson County and its immediate surrounding areas.

DEA Retail Drug Summary. We obtained 2016 retail drug summary published by the Drug Enforcement Agency. It is a breakdown of retail sales (in kg) for all scheduled drugs by 3-digit zip code and drug type (Drug Enforcement Administration, 2017). This information provides insight into prescription drugs supplied to the Kansas City metropolitan area.

DAWN Metropolitan Reports. The Drug Abuse Warning Network (DAWN) is a surveillance system that monitors trends in substance misuse and substance use disorders (Substance Abuse and Mental Health Services Administration, 2012). It uses data from drug-related hospital emergency department visits to identify emergence of new drugs or combination of drugs.

Hospital Discharge Data. We obtained 2015 counts for hospitalizations related to alcohol poisonings or drug poisonings from the Missouri Department of Mental health by county and 5-year counts by zip code. This data was not available from the State of Kansas at the county or zip code level. Please note that all counts less than five individuals were suppressed; these were recoded as “less than five”.

Medicaid Part D. We obtained 2014 Medicare Part D claims data for opioid prescriptions (Center for Medicare & Medicaid Services, 2017). We reported the data as a county-specific rate: the number of opioid prescription claims per 100 Medicare Part D claims.

Other Data Sources. We obtained information from other reports related to the Kansas City metropolitan areas, such as 2017 data from the Jackson County Police Department regarding opioid-related arrests, 2017 Missouri Department of Mental Health Community Epidemiological Profiles, and 2015 SAMHSA data on identified service gaps for formal addition treatment services.

Analytic Procedures

We geocoded all facility locations to point locations using ArcGIS 10.3. We aggregated this information to census tract, county, 3-digit zip code, and 10-county MARC region to align with varying geographic resolutions available for the population indicators of risk and need. We created all maps using ArcGIS 10.3.

Limitations

Readers should interpret subsequent findings with key limitations in mind. First, we did not survey or interview the consumers of these services. This data best represents the experiences and perspectives of policy-makers, funders, coalition members, and/or providers. Second, it is likely we did not capture facilities that were not listed in referral databases, did not participate in local coalitions, or were not licensed through state organizations. Finally, we did not explicitly assess for harm reduction practices that may be essential to client engagement and/or overdose prevention.
CHAPTER 3. THE POLICY CONTEXT: A TALE OF ONE METROPOLIS ACROSS TWO STATES

Introduction

The Kansas-Missouri state line bisects the Kansas City metropolitan area. This geographic boundary lends itself to natural service delivery challenges related to policy and funding. A complete policy analysis of this phenomenon was outside the scope of our study; however, the vast majority of stakeholders mentioned this specific challenge. They discussed balancing how best to serve clients and communities with navigating the politics of two states. This chapter briefly highlights state level forces identified by these stakeholders that may influence the SUD continuum of care within the Kansas City metropolitan area.

Common Concerns Mentioned in Stakeholder Interviews

Sticking to One Side of the State Line. Approximately 90% of the stakeholders that we interviewed brought up their concerns or frustrations around the Kansas-Missouri state line bisecting the Kansas City metropolitan service area. These stakeholders ranged from representatives of federal government agencies to for-profit providers of small, single site agencies. Stakeholders discussed the need to “stick to one side of the state line” as they highlighted the difficulties of learning how to adhere to state-level regulations, licensing, or registration for one state. Some private practitioners even felt this tension given their most reliable referral sources often came from relationships that they had built with specific government agencies. At minimum, many providers have created a barrier in their mind between the Kansas and Missouri sides of the Kansas City metropolitan area. For example, when we approached organizations in the Kansas counties, providers consistently seemed surprised that we were speaking with them because we were updating a referral database for an agency on the Missouri side of the state line.

Funding Dictates Services. To serve low-income populations, agencies are dependent upon distribution of block grant funds by their respective state agencies. Stakeholders emphasized that, at the end of the day, services are dependent upon funding streams, and distribution of Medicaid funds creates a natural division of resources across the Kansas City metropolitan area. Federal grant or foundation funds provide more flexibility for organizations; however, these programs are often resource- and time-limited.

Differences in Who One Can Hire. Stakeholders emphasized that they must employ qualified substance abuse professionals to be able to bill for services. They described that the differences in licensing requirements between Kansas and Missouri for addiction counselors affects who they can hire; however, individuals’ perceptions of the relative benefits or quality of the workforce associated with each set of licensure requirements differed widely.
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**Differences in Prescription Drug Monitoring Programs.** Stakeholders concerned about opioid prevention and/or aligned with the medical field emphasized their frustration about the lack of coordination of prescription tracking across Kansas and Missouri. Specifically, Kansas practitioners emphasized that Missouri does not participate in an interstate system like the other surrounding states; sharing this information with prescribers is a recommended prevention measure to deter nonmedical use of prescription opioids. As a result, Kansas stakeholders reported that they are unable to track if clients are “jumping the state line” to obtain prescriptions on the Missouri side of metropolitan area. Interstate cooperation of prescription drug monitoring programs (PDMPs) for geographic regions like the Kansas City metropolitan area can work to reduce overall non-medical prescription drug use by providing medical practitioners with information about patients who may be “double doctoring” or “prescription shopping” (Fischer, Bibby, & Bouchard, 2010).

**Assessment of Policy-related Concerns**

While a policy analysis was outside the capacity of our assessment, we encourage others to conduct a comprehensive analysis on the impact of the following macro-level forces on the Kansas City metropolitan area:

- State-level differences in substance use disorder (SUD) funding and services administration
- State-level differences in workforce training and licensing
- State-level differences in criminal law, sentencing, and other practices
- State-level differences in prescription tracking practices
- State- and county-level clustering of referral networks across agencies
- Collaboration efforts across Kansas and Missouri state and county agencies
CHAPTER 4. OVERVIEW OF THE DRUG ENVIRONMENT

Introduction

The drug environment comprises the broader context that influences substance-related behaviors. Given substance use behaviors and their related problems are viewed as taboo behaviors in the United States, it can be difficult to obtain accurate counts of actual use and misuse. As a result, we estimated risk and need uses multiple sources of information. These data sources can include population-level demographics associated with high risk for substance use disorders (SUD), indicators of drug supply (both licit and illicit), indicators of high-risk behaviors such as adolescent use trends, or substance-related consequences such as substance-related poisonings and deaths. We can obtain information about the drug environment to target high-risk contexts where there are likely to be the highest need for substance-related prevention and/or intervention. In this chapter, we report on a variety of population-level indicators of risk and need for substance-related services. The chapter concludes with a summary that aims to integrate the multiple sources into a global assessment of prevention and intervention needs by county.

Kansas City Metropolitan Area

Table 4.1 shows the population distribution across the Kansas City metropolitan area, which is composed of a mix of urbanized, suburban, and rural environments. For example, Jackson County has the highest population, estimated to be over 650,000 individuals in 2016. In contrast, Lafayette and Ray counties are estimated to be composed of less than 35,000 individuals.

Identifying Populations & Communities At-Risk for SUD

High Risk Communities

Neighborhood disadvantage, typically defined by socio-economic indicators such as high household poverty and high unemployment rates, are associated with a higher risk for drug use among adults (Boardman, Finch, Ellison, Williams, & Jackson, 2001) and adolescents (Fite, Wynn, Lochman, & Wells, 2009). These are “upstream” risk factors that likely increase stressors experienced by individuals living within these environments. Table 4.2 show the distribution of households below the 100% federal poverty line. Based on this lens, the highest risk county environments for substance-related problems would be Wyandotte (MO), Jackson (MO), Ray (MO), and Johnson (MO) counties at 15% poverty or above.
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Figure 4.1 Total Population by County

Figure 4.2 Percent of Households Below 100% Federal Poverty Line
**Prescription Drug Supply**

Indicators that capture prescription drug supply can identify where individuals may have higher access to prescription medications. While the majority of the legal drug supply is likely destined for intended medical use, understanding supply can help us identify where there may be higher risk for youth access to medications or diversion of unused medication to unintended populations. Figure 4.3 shows opioid-specific claims from Medicaid Part D (CMMS, 2017) while Figure 4.4 shows prescription retail sales of oxycodone tracked by the Drug Enforcement Agency (DEA, 2017). In Figure 4.4, we see distinctive differences in oxycodone sales on either side of the state line for the Kansas City metropolitan area, with the highest quantities observed on the Missouri side. Stakeholders on the Kansas side reported concern about being unable to track opioid prescriptions from Missouri, which allows individuals to more easily fill multiple prescriptions by crossing the state line.

Figure 4.3 Medicaid Part D 2014 Opioid Prescription Rates (per 100 claims)
Shifting Illicit Drug Markets

One major indicator of impending service needs involves shifts in illicit drug market activity. For example, an increase in opioid supply on the streets is typically a precursor for opioid overdoses and opioid-related deaths.

Service providers should coordinate efforts with local police departments and emergency service personnel to identify rising illicit drug markets and develop services that can target early intervention and/or connect qualified individuals to early treatment. For example, Jackson County Police Department shared their data on opioid overdose “hot spots” (based on counts of Narcan administration) with the Opioid Treatment Work Group during May 2018. This type of collaboration allows service providers to coordinate with emergency personnel to target outreach and engagement efforts in neighborhood areas with higher rates of opioid-related overdoses and deaths.
Adolescent Substance Use Trends

Across all counties, adolescents primarily reported using alcohol and cigarettes (Missouri Department of Mental Health, 2017). However, percent of adolescents reporting prescription drug use (ranging from 7.7% to 10.5%) were higher than those reporting binge drinking or marijuana use for all counties. These numbers represent youth engage in high-risk substance use behaviors that could benefit from targeted prevention efforts to prevent the future development of substance use disorders, overdoses, and/or deaths. Figure 4.5 shows the variation in percentages for prescription drug use across counties with the highest percentages (9% or more) observed in Johnson County, MO and Jackson County, MO.

Figure 4.5. Adolescent Self-reported Prescription Drug Use in 2017 by County
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Identifying Communities in Need of Treatment & Recovery Services

*Origins of Clients Associated with Service Referrals*

New technology is developing, such as the Community CareLink, which facilitates referrals between agencies. As a proxy for need, we used this data to visualize the zip code of origin for clients that First Call’s Crisis hotline referred for services and between agencies that were using this system. While limited in the scope of services and geographic regions capture by this pool of agencies, this information highlights that individuals across the metropolitan area are seeking services. However, for these agencies, there is a higher concentration of individuals seeking services within specific areas of Jackson and Clay (MO) counties.

**Figure 4.6 Origin of Clients Seeking SUD-Related Services**

*Hospitalizations for Alcohol and Drug Poisonings*

Hospital discharge data from Missouri shows significant differences across counties in rates for alcohol and drug poisonings. We observed the highest hospitalization rate for alcohol poisoning in Jackson County, MO; in contrast, we observed the highest hospitalization rate for drug poisoning in Lafayette County, MO.
Figure 4.7 Hospitalization Rate for Alcohol Poisonings by County

Legend
- State Line
- Midwestern Counties
- Poisoning Rate per 10,000 Adult Population
  - Less than 10.0
  - 10.0 - 13.9
  - 14.0 - 17.9
  - 18.0 - 21.0
  - 22.0 or More
  - Data Not Available

Figure 4.8 Hospitalization Rate for Drug Poisonings by County

Legend
- State Line
- Midwestern Counties
- Poisoning Rate per 10,000 Adult Population
  - Less than 10.0
  - 10.0 - 13.9
  - 14.0 - 17.9
  - 18.0 - 21.0
  - 22.0 or More
  - Data Not Available
When we looked at actual hospitalization counts by zip code over 5 years, we observed that high-count zip codes (126 drug-related hospitalizations or more) were predominantly within Clay and Jackson (MO) counties. That being said, the drug-related hospitalization counts in Ray and Johnson (MO) counties are concerning, given their comparatively smaller population size.

**Figure 4.9: Five year count of hospital discharges for drug poisonings by zip code**

![Map showing hospital discharges by zip code](image)

*Legend*
- State Line
- KC Metro Counties
- Midwestern Counties
- Number of Hospitalizations for Alcohol Poisonings
  - 0 to 5
  - 6 to 25
  - 26 to 75
  - 76 to 125
  - 126 or More
  - No Data Available

**Alcohol- and Drug-related Deaths**

In 2010, DAWN reported county profiles for major metropolitan areas. In Jackson County, drug-related deaths were reported a rate of 15.7 per 1,000,000 population. Drug-related deaths were associated with the following drugs (in rank order from largest to smallest number of deaths): opiates/opioids, cocaine, alcohol, benzodiazepines, and stimulants (SAMHSA, 2012). From 2012 to 2018, the drug-related death rate increased by approximately 13% to 17.7 per 100,000 population in Jackson County (CDCP, 2017).
Between 2012 to 2016, alcohol- and drug-related death rates were 20.6 per 100,000 population for Kansas and 26.6 per 100,000 population for Missouri. Jackson County, MO substance-related death rate of 29.5 deaths per 100,000 population is higher that observed for the state of Missouri. To give some context, this rate is almost three times that of vehicle-related deaths for the same period of time (CDCP, 2017).

When looking at the KC metropolitan area more broadly, we see variation in alcohol- and drug-related death rates from 2012 to 2016 (CDCP, 2017). Figure 4.10 shows the substance-related death rates (that include deaths associated with alcohol and/or other drugs) by county in the Kansas City metropolitan area. While we see the highest death rates within the urban core (Jackson County, MO), we also observed substantially high death rates in the less urbanized, northern counties of Leavenworth (KS), Clay (MO), and Ray (MO). County-specific, opioid-related death rates were low enough to be suppressed for this time range and are not reported.

Figure 4.10: County-specific alcohol- and drug-related crude death rates (per 100,000 population) for the period between 2012 and 2016
Assessment of SUD Risk & Treatment Need in the KC Metropolitan Area

Substance use and misuse is a complex, multidimensional phenomenon. Each population indicator provides us with a different perspective into SUD risk and need for services. Table 4.1 provides a summary of the highest risk/need contexts within the Kansas City metropolitan area across the range of population indicators discussed in this chapter. Not surprisingly, we identified Jackson County, MO with its dense, urban environment as a high risk/need context across all population indicators. In addition, increases in the drug-related death rates highlight that there is a growing need for services. Indicators for Ray County, MO demonstrated higher levels of poverty, drug supply, and substance-related deaths than surrounding counties, suggesting a high need for services in this area.

The table below also provides insights into specific needs across county contexts. For example, Johnson County, MO demonstrated a high percentage of adolescent prescription drug use. This county is likely a prime target for prevention efforts that focus on educating youth about the harms of these behaviors and on mitigating harms related to prescription drug misuse. Alternatively, Wyandotte County, KS appears to be a high-risk drug environment related to demographic stressors (i.e., high levels of poverty) and available drug supply. Finally, Leavenworth County, KS appears to have a high substance-related death rate despite reporting low to average levels on other population indicators, suggesting further investigation into available supports and services focused on preventing substance-related deaths.

Table 4.1: Summary of High-Risk Drug Environment by County

<table>
<thead>
<tr>
<th>County</th>
<th>Demographic Risk</th>
<th>Drug Supply</th>
<th>Adolescent Use</th>
<th>Service Calls</th>
<th>Hospitalizations</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson</td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leavenworth</td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Wyandotte</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cass</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clay</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jackson</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Johnson</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lafayette</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Platte</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ray</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21
CHAPTER 5. UNDERSTANDING THE SUD CONTINUUM OF CARE

Introduction

For the purposes of this assessment, we defined the substance use disorder (SUD) continuum of care broadly. We were interested in understanding the range of services that existed in the Kansas City metropolitan area and addressed the needs of individuals at-risk of developing a SUD, in need of treatment (both formal and informal), and in recovery from a SUD. This chapter provides an overview of all agencies and facilities that we identified through our procedures, were currently in operation, and actively provided services along the SUD continuum of care. This chapter provides a bird’s eye view of the variation in agency types, services being provided, and geographic distribution of facilities. It helps us to begin answering questions about who is being served, what services are being provided, and where services are located. We provide a detailed analysis of opioid-specific services in Chapter 6 and of services by level of care in Chapter 7.

Understanding the Agency Context

We identified 216 agencies providing substance-related services between September 2017 to March 2018. Of these, 108 (50%) identified as a private, for profit agency; 83 (38%) identified as a private, non-profit agency; 13 (6%) identified as a faith-based organization; and 12 (6%) identified as a local, state, or federal government agency. In addition, 34% of these identified agencies primarily focused on substance use disorder (SUD) prevention/treatment services. Another 45% provided these services within integrated settings, providing health and/or mental health services in addition to SUD services.

Table 5.1: Payment Options Reported by Agencies (N = 216)

<table>
<thead>
<tr>
<th>Payment Options</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free for Clients</td>
<td>39</td>
<td>18.1</td>
</tr>
<tr>
<td>Cash or Self-Pay</td>
<td>178</td>
<td>82.4</td>
</tr>
<tr>
<td>Medicare</td>
<td>22</td>
<td>10.2</td>
</tr>
<tr>
<td>Medicaid</td>
<td>53</td>
<td>24.5</td>
</tr>
<tr>
<td>Private Health Insurance</td>
<td>64</td>
<td>29.6</td>
</tr>
<tr>
<td>State/Federal Funds</td>
<td>26</td>
<td>12.0</td>
</tr>
<tr>
<td>Grant Coverage</td>
<td>12</td>
<td>5.6</td>
</tr>
<tr>
<td>TRICARE/Military Insurance</td>
<td>9</td>
<td>4.2</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Payment options were diverse, but 40% of agencies reported that they accepted cash/self-pay only. This severely limits the financial affordable options across all services. While approximately 30% of agencies accept
Medicare/Medicaid or support clients through grant funds, stakeholders reported the funds to support these clients typically run out before the end of the fiscal year. For example, Kansas providers consistently reported FY18 block grant funds were depleted by the beginning of the fourth quarter. Table 5.1 shows the distribution of payment options reported across agencies.

When asked about faith-orientation of services, 142 (66%) agencies reported secular-oriented approaches. Approximately 14% identified as faith-secular to faith-affiliated, defined by providing little to no explicit religious content; however, these agencies may either collaborate with faith-based organizations or encourage religious participation and directly makes spiritual resources available to participants. Twenty percent of services reported either being faith-centered (e.g., religious activities are provided but participants can readily opt out) or faith-permeated (e.g., participation in religious activities are required).

Spanish language services were extremely limited with only 10% of agencies reporting any staff that were Spanish speaking. Interviews with stakeholders reflected a similar reality. Within the private, for profit sector, Spanish-speaking providers reportedly are able to charge more per hour for services. Within the private, non-profit sector, Spanish-speaking providers have been difficult to recruit and retain:

The Latino population of Kansas City, Missouri; Kansas City, Kansas; Topeka; Edwardsville; and other areas are experiencing a great need for SUD services in Spanish that are also affordable and accessible. Recently, over the past 18 months or so, these communities have lost Spanish-speaking, ‘certified’ counselors to retirement, career changes, or illness/death. Three locations that served Latinos, have closed. Add to that, the fact that there is minimal interest to enter this field by individuals who are fluent in Spanish.

While another 10% services reported use of on-call interpreters for Spanish-speaking clients, these findings suggest a multidimensional response is needed to improve language-appropriate SUD services:

1. recruitment and training of Spanish-speaking professionals;
2. increase use of on-call interpretation services to alleviate gap in professional staff; and
3. strategically target geographic location of Spanish-speaking providers based on available demographics to where Spanish-speaking services are most likely needed.

Availability of language-appropriate services was even more limited for populations identifying as deaf or hard of hearing. We recommend similar efforts to increase professional capacity for these services. Current initiatives support a move in this direction, such as on-call interpretation services being required by Johnson County, KS to increase accessibility and adequacy of services for these populations.

We obtained inconsistent responses regarding the racial/ethnic demographics of clients served by each facility. As a result, we could not reliably report trends regarding these client demographics; however, we would like to highlight that racial/ethnic disparities arise primarily around treatment (as opposed to differential need) and correspond with treatment affordability (Guerrero, Garner, Cook, Kong, Vega, & Gelberg, 2017). Issues related to services availability based on other demographics, such as age and gender identification, are specific to facility locations and their associated services rather than the broader agency context. We highlight some of these findings in Chapter 7 when discussing services by level of care.
The Size & Scope of Substance-Related Services

The agencies significantly varied in size and scope of services. To better understand the service sector, we identified the 410 facility locations providing 1,028 different types of services across these agencies. In addition to these facilities, we also identified 371 unique, registered mutual aid groups across the Kansas City metropolitan area. Table 5.2 shows the range of services, the proportion of facilities providing these services, and the proportion of total services that each service type represents. Please refer to Chapters 6 and 7 for a detailed analysis of each service type.

Table 5.2: Types of Formal Services Composing the SUD Continuum of Care

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Count</th>
<th>Percent of Facilities</th>
<th>Percent of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT Administration/Monitoring</td>
<td>90</td>
<td>22.0</td>
<td>8.8</td>
</tr>
<tr>
<td>Methadone</td>
<td>8</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>70</td>
<td>17.1</td>
<td></td>
</tr>
<tr>
<td>Naltrexone</td>
<td>36</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>Detox</td>
<td>35</td>
<td>8.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Medical</td>
<td>9</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>27</td>
<td>6.6</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>9</td>
<td>2.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Residential</td>
<td>30</td>
<td>7.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Tx</td>
<td>15</td>
<td>3.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>99</td>
<td>24.1</td>
<td>9.6</td>
</tr>
<tr>
<td>Traditional Outpatient</td>
<td>178</td>
<td>43.4</td>
<td>17.3</td>
</tr>
<tr>
<td>Recovery-oriented Services</td>
<td>196</td>
<td>47.8</td>
<td>19.1</td>
</tr>
<tr>
<td>Aftercare Support/Coaching</td>
<td>94</td>
<td>22.9</td>
<td></td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>128</td>
<td>31.2</td>
<td></td>
</tr>
<tr>
<td>Peer Mentoring</td>
<td>88</td>
<td>21.5</td>
<td></td>
</tr>
<tr>
<td>Community Center/Space</td>
<td>4</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Screening &amp; Assessment</td>
<td>225</td>
<td>54.9</td>
<td>21.9</td>
</tr>
<tr>
<td>Prevention</td>
<td>89</td>
<td>21.7</td>
<td>2.8</td>
</tr>
</tbody>
</table>

These facilities varied in the clientele they served. Fifty-two percent of the facilities reported providing at least one program designed to address the needs of specific populations. For example, 172 (42%) served adolescent clients (with 20% specializing in adolescent treatment) in comparison to 370 (90.2%) that service adult clients (ages 18+ years). Table 5.3 show the number and percent of facilities reporting specialized services for a range of population needs. It is important to note that gender-specific services were primarily composed of residential treatment or housing-based recovery services, and these services rarely reported accepting clients who identify...
as transgender\(^1\). In addition, only three facilities reported providing specialized care for LGBTQIA+ populations, representing a huge gap in services for individuals who are at higher risk for substance-related problems due to increased exposure to stress related to discrimination, violence, and marginalization (McCabe, West, Hugh, & Boyd, 2013; Medley, Lipari, Bose, Cribb, Kroutil, & McHenry, 2016).

Table 5.3: Specialized Services Offered by Identified Population

<table>
<thead>
<tr>
<th>Type of Population</th>
<th>Count</th>
<th>% Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents Only</td>
<td>81</td>
<td>19.8</td>
</tr>
<tr>
<td>Women Only</td>
<td>43</td>
<td>10.5</td>
</tr>
<tr>
<td>Transgender Inclusive</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>Men Only</td>
<td>67</td>
<td>16.3</td>
</tr>
<tr>
<td>Transgender Inclusive</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>LGBTQIA+</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Parenting Population</td>
<td>66</td>
<td>16.1</td>
</tr>
<tr>
<td>Pregnant/Post-partum Women</td>
<td>18</td>
<td>4.4</td>
</tr>
<tr>
<td>Women with Children</td>
<td>40</td>
<td>9.8</td>
</tr>
<tr>
<td>Men with Children</td>
<td>14</td>
<td>3.4</td>
</tr>
<tr>
<td>Families in General</td>
<td>24</td>
<td>5.9</td>
</tr>
<tr>
<td>Veterans/Active Military</td>
<td>13</td>
<td>3.2</td>
</tr>
<tr>
<td>Dually Diagnosed MH+SUD</td>
<td>76</td>
<td>18.5</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>80</td>
<td>19.5</td>
</tr>
<tr>
<td>DUI-specific Services</td>
<td>52</td>
<td>12.7</td>
</tr>
<tr>
<td>Other</td>
<td>39</td>
<td>9.5</td>
</tr>
</tbody>
</table>

Figure 5.1 shows the geographic distribution of all 410 facilities overlaid on county total population (based on 2016 American Community Survey estimates). This map demonstrates how the service distribution appears to align with population distribution, such that services are concentrated where individuals are concentrated.

However, the location of need for SUD-related services may not align with population density. In a time where resources are limited, prevention and intervention efforts should target populations with the highest risk and/or need. Figure 5.2 show a slightly different perspective into the distribution of services by showing the number of facility locations for every 10 substance-related deaths within each county. From this perspective, Platte County, MO and Cass County, MO have less than 1 facility for every 10 substance-related deaths that were identified between 2012 to 2016. In contrast, we observed Wyandotte County, KS and Johnson County, KS had the largest number of facilities (2 or more) offering substance-related services relative to substance-related deaths observed within this county. Using a needs-based denominator suggests overall accessibility to local SUD-related services is limited within less urbanized counties.

\(^1\) We asked facilities if they accepted clients who identified as male, female, or transgender. We did not ask the facility to specify if a specific gender identification was required for transgender clients to be eligible for services.
Figure 5.1: Identified Facility Locations Overlaid on County Total Population

Figure 5.2: Number of Facility Locations per Substance-Related Death by County
Service Gaps: Assessment & Recommendations

(1) *The SUD continuum of care is strong but not enough to curb rising drug-related overdoses and deaths.* We identified services that cover the full range of care from prevention to treatment to recovery supports; however, the service availability and capacity were insufficient to ebb the tide of drug-related overdoses and deaths discussed in Chapter 4. The assessment identified potential areas to further explore and/or intervene: (i) develop partnerships between first responders and service providers to create better engagement into treatment; and (ii) develop partnerships between agencies or develop more services that specifically address the service gaps that arise from extensive waitlists for clients as they step down to less intensive levels of care (e.g., detox/inpatient → residential facilities; residential facilities → recovery housing).

(2) *The substance-related risks are high in many rural counties, yet service density is low.* Stakeholders cautioned that addressing rural community needs likely is not as easy as transplanting addiction models that work for urban environments. For example, it may not be financially viable to support a satellite office within a rural county where clients would still be required to travel far distances. Some private outpatient providers reported that they have begun to explore telemedicine to address these concerns. Alternatively, recovery housing that are remote from adjunctive counseling, employment, and other support services may increase hardships for residents. Alternative strategies, such as peer recovery mentors or promotion of other low-cost solutions such as online recovery support groups, may provide short-term solutions to address immediate needs for individuals residing in these less dense communities while other geographically-appropriate models are developed.

(3) *The relative availability of services (and associated funding sources) for low-income populations is insufficient to address service demand.* The number of available services were highest for clients who have sufficient financial resources of pay out-of-pocket for services. This was not the case for low-income populations who qualify for Medicaid, as suggested by Kansas practitioners reporting funds were depleted by the end of the third quarter. Affordability is a likely an even larger issue than we have assessed here, given we did not specifically address the gap that exists for: (a) clients who do not qualify for Medicaid, (b) clients who have insufficient private medical coverage, and (c) clients who cannot afford to pay out-of-pocket. Federal or state funding for SUD services should be increased to minimize previously documented disparity in treatment outcomes observed for low-income individuals and their families (Guerrero et al., 2017).

(4) *The SUD continuum of care lacks the capacity to serve non-English speaking populations.* Providers reported a lack of sufficient work force to address the language needs of clients in the Kansas City metropolitan area. Even when we factored in reported use of on-call interpreters, only 20% of agencies reported being able to provide language-appropriate services for clients. As a first step, increasing use of on-call interpreters would address an immediate need. Providers also may want to explore collaborating with community leaders and other natural helpers within the community to increase visibility and accessibility of these services. As a long-term goal, recruitment and training of providers with a range of language skills will be essential to creating a more inclusive continuum of care.
The availability of services specializing in addressing the needs of high-risk, vulnerable populations, such as pregnant and post-partum women (PPW) or individuals identifying as LGBTQIA+, is relatively low. The SUD continuum of care appeared to have diversified to allow for a variety of services specializing in addressing the needs of adolescents, women, and faith-oriented clients. These are likely due to specific initiatives to increase services to these populations, such as the Access to Recovery (ATR) vouchers in Missouri that included faith-based organizations. However, the proportion of facilities providing services for other high-risk, vulnerable populations such as PPW and individuals identifying at LGBTQIA+ were comparatively low. Practitioners should consider developing specialized services for these populations that can address their unique needs and create inclusive, safe spaces.
CHAPTER 6. SERVICES ADDRESSING OPIOID USE DISORDERS

Introduction

Opioid-related overdoses and deaths are increasing nationwide (Hedegaard, Warner, & Miniño, 2017). Figure 6.1 shows the trends in opioid overdose death rate (per 100,000 population) by race/ethnicity. (Please note that the data was only reliable for individuals identified as White and non-Hispanic for Kansas and for individuals identified as White or Black and non-Hispanic for Missouri.) The rate of opioid overdose deaths is rising in both Kansas and Missouri; however, we are seeing a steeper trend for Missouri. The spike in opioid overdose deaths among individuals identified as Black and non-Hispanic is particularly alarming and suggests targeted outreach in communities of color may be necessary to curb this trend and engage clients into services when possible.

Figure 6.1: Trend of Opioid Overdose Death Rate per 100,000 Population by Race/Ethnicity

Community members, policy makers, and providers have a chance to respond to this growing need in order to ebb the tide of opioid-related overdoses and deaths. This section highlights information we obtained about how the substance use disorder (SUD) continuum of care is currently addressing opioid misuse. We hope this serves to identify potential areas for growth that can help us create a more responsive continuum of care before opioid-related overdoses and deaths rise to epidemic levels in our region.

According to the National Institute on Drug Abuse (2016), the use of medication in conjunction with counseling services, referred to as medication assisted treatment, is considered the best practice for addressing opioid use disorder. In fact, medication is one of many treatments, such as behavioral counseling and recovery supports, that individuals need to address their recovery needs holistically (NIDA, 2016). This chapter explains the range of MATs available, the availability of MATs and other opioid-focused services in the Kansas City metropolitan area, and the tolerance of MATs use by clients across the SUD continuum of care.

Understanding Medication Assisted Treatment for Opioid Use Disorder

Medication assisted treatment for opioid use disorders is associated with significant decreases in opioid-related overdoses and deaths (Schwartz et al., 2013) and with significant increases in social functioning and treatment retention (Potter et al., 2015).

Table 6.1 provides a brief summary of the commercial names, formulations, potential benefits, and potential harms for the four types of medications that are important to understand when considering the use of MATs. Naloxone is an opioid antagonist that binds to the opioid receptors in the brain without activating them; as a result, this drug blocks the opioid receptors and prevents individuals from feeling the effects of opioids. It is commonly used to prevent opioid-related overdose. Methadone is full agonist opioid that activates the opioid receptors in the brain fully resulting in the full opioid effect. In contrast, Buprenorphine is a partial agonist opioid that bind to the opioid receptors in the brain but does not produce the full opioid effect. Both methadone and buprenorphine appear to be useful in reducing withdrawal symptoms during detoxification; methadone appears to be more effective in managing opioid use disorder over time despite buprenorphine having a lower misuse potential than methadone (Whelan & Remski, 2012). Buprenorphine often is combined with naloxone to further minimize its misuse potential; for example, naloxone will overpower the effects of buprenorphine if tablets are crushed and subsequently snorted or injected; however, naloxone does not have the same effect when taken orally. Naltrexone is an opioid antagonist used to help individuals maintain their recovery from opioid use disorders, but unlike the agonist opioids, naltrexone has no misuse or diversion potential. However, a client must be detoxed fully before using naltrexone, making it less useful to engage active users into treatment (NIDA, 2016; SAMHSA, 2015).
Table 6.1: FDA-Approved Medication Assisted Treatments for Opioid Use Disorder

<table>
<thead>
<tr>
<th>Substance</th>
<th>Commercial Name</th>
<th>Formulations</th>
<th>Potential Benefits</th>
<th>Potential Harms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naloxone (Antagonist)</td>
<td>NarCan, Evzio</td>
<td>Nasal Spray Autoinjectable, Injectable</td>
<td>• Can rapidly reverse opioid overdose by restoring natural respiration &lt;br&gt;• No misuse or diversion potential</td>
<td>• Can cause withdrawal symptoms such as headache, changes in blood pressure, rapid heart rate, sweating, nausea, vomiting, and tremors</td>
</tr>
<tr>
<td>Methadone (Full Agonist)</td>
<td></td>
<td>Oral (pill), Oral (liquid), Oral (wafer)</td>
<td>• Reduces opioid-related withdrawals and cravings &lt;br&gt;• Safe when taken as prescribed &lt;br&gt;• Affordable &lt;br&gt;• Can be safely used in treatment of opioid-dependent pregnant women, reducing NAS symptoms for their babies</td>
<td>• Side effects can be severe, including chest pain and pounding heartbeat &lt;br&gt;• Can be addictive or cause unintentional overdose if not taken as prescribed &lt;br&gt;• Distribution restricted to opioid treatment programs (OTP) decreasing treatment access</td>
</tr>
<tr>
<td>Buprenorphine (Partial Agonist)</td>
<td>Subutex, Suboxone, Bunavail, Zubsolv, Sublocade, Probuphine</td>
<td>Oral (tablets), Oral (film), Oral (buccal film), Oral (tablets), Injectable Implant</td>
<td>• Reduces opioid-related withdrawals and cravings &lt;br&gt;• Safe when taken as prescribed &lt;br&gt;• Can be prescribed or dispensed in physician offices increasing treatment access &lt;br&gt;• Lower misuse potential than methadone &lt;br&gt;• Can be safely used in treatment of opioid-dependent pregnant women, reducing NAS symptoms for their babies</td>
<td>• Tablet forms (even those combined with naloxone) may be misused for psychoactive effects or self-treatment of opioid use disorder &lt;br&gt;• Tablet forms (that are not mixed with naloxone) may be misused by being crushed and snorted/injected to increase effects &lt;br&gt;• Side effects of euphoria or respiratory depression may occur but are weaker than heroin or methadone</td>
</tr>
<tr>
<td>Naltrexone (Antagonist)</td>
<td>ReVia, Depade, Vivitrol</td>
<td>Oral (pill), Injectable</td>
<td>• Prevents feeling the euphoric effects of opioids &lt;br&gt;• Safe when taken as prescribed &lt;br&gt;• Can be prescribed or dispensed in physician offices increasing treatment access &lt;br&gt;• No misuse or diversion potential</td>
<td>• Requires full detoxification before use &lt;br&gt;• May reduce tolerance to opioids, resulting in higher chance of overdose if relapse occurs after a period of abstinence &lt;br&gt;• Side effects can include gastrointestinal issues, headache, nervousness, sleep problems, or joint/muscle pain</td>
</tr>
</tbody>
</table>

Sources: National Institute on Drug Abuse (2016); Substance Abuse and Mental Health Services Administration (2015)
Services Specializing in Treatment of Opioid Use Disorder

Approximately 30% of facilities reported not accepting clients using MATs and/or not treating opioid-related concerns. In contrast, 22% of facilities reported administering or monitoring MATs on site. Eight facilities reported administering methadone, 70 facilities reporting administering buprenorphine, and 36 facilities reported administering naltrexone. These sites often specialized in opioid-related treatment needs such as detoxification, inpatient services, and/or outpatient psychiatry.

Figure 6.1: Geographic Distribution of Facilities Providing MAT Services

Specifically, seven medical detoxification facilities reported provided opioid-specific services where they administer and/or monitored MATs on site. In contrast, 24 outpatient detoxification facilities were identified that addressed opioid-related needs. We also identified six inpatient units and eight residential facilities that were designed to administer and/or monitor MATs on site to assist in the early stages of recovery from opioid used disorder. This translated into an estimated 239 inpatient beds and 169 residential beds in facilities that supported opioid-specific treatment needs but also accept individuals seeking treatment for a range of substance-related disorders. To place these numbers in context, over 1500 individuals were hospitalized for drug-related poisonings in 2016 on the Missouri side of the state line. Waitlists for detox and inpatient units was variable because of the short-term nature of patient stays; however, waitlists between a month to 90 days were consistently reported for residential treatment facilities.
Stakeholder interviews identified a clear gap in the continuum of care when clients were being discharged from detoxification and short-term inpatient hospitalization and required less intensive services to manage their recovery. One social worker who coordinated care between a detoxification unit and follow-up care described challenges obtaining long-term inpatient or residential care for individuals who had successfully detoxed; to fill this gap, these clients were referred into intensive outpatient programs while on waitlists for services providing more controlled environments. Some agencies, like Artists Helping the Homeless, provide temporary housing to address the gaps that arise when individuals are required to wait for services in the process of leveling down from hospitalized settings to residential services. That being said, these types of services are extremely limited within the Kansas City metropolitan area. This gap is particularly concerning because of the higher likelihood of opioid-related overdose and death of individuals relapse after detoxification or during early stages of recovery (World Health Organization, 2014).

Finally, the higher likelihood of opioid-related overdose and deaths places unique stressors on the families of these individuals. One stakeholder identified that there are no dedicated spaces for individuals to process these unique loss and grief experiences, which cannot be adequately addressed through traditional bereavement groups and do not always align with the focus of mutual aid groups, such as Alanon. In addition, children of individuals who are addicted to opioids are vulnerable to potential neglect and abandonment through exposure to parental substance use, associated functional impairments, and parental overdose and death (Kepple, 2017; Wilens et al., 2002).

Tolerance of Medication Assisted Treatment (MAT) for Opioid Use Disorder

Services across the continuum of care varied in their acceptance of clients using medication assisted treatment (MAT) for opioid use disorder. Approximately 45% of facilities reported that they accepted clients using MATs for opioid use disorder; however, 59 (33%) out of the 181 facilities accepting clients using MATS reporting imposing additional restrictions or having reservations about accepting clients on MATs.

We also observed the distribution of MAT tolerance varied significantly by type of services being provided. (Table 6.2 breaks down reported MAT tolerance by type of service.) Overall, we observed services focused on higher levels of care are more open to MATs. In fact, MATs are typically administered in stand-alone physician practice (private, for profit) or in multi-site, multi-service agencies through in-house psychiatrists working with interdisciplinary staff (private, non-profit). VA Hospitals also support MATs and have a long history developing and supporting these practices. However, these represent a low proportion of services available.

We observed a lower proportion of less intensive services available for MAT users, specifically intensive outpatient, outpatient, and recovery supports (particularly housing). Yet, these lower levels of care are necessary to sustain individuals in their recovery process, especially in light of evidence that recovery is a long-term process and using MATs to maintain recovery is most effective with therapeutic support (Harris, Smock, & Wilkes, 2011; Kaskutas et al., 2014; NIDA, 2016).
Table 6.2: MAT Tolerance by Service Type

<table>
<thead>
<tr>
<th>MAT Tolerance</th>
<th>Detox</th>
<th>Inpatient</th>
<th>Residential</th>
<th>Partial Hosp / Day Tx</th>
<th>IOP</th>
<th>OP</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT not allowed and/or does not treat opioid-related concerns.</td>
<td>1 (2.9%)</td>
<td>1 (11.1%)</td>
<td>8 (26.7%)</td>
<td>2 (13.3%)</td>
<td>20 (20.2%)</td>
<td>38 (22.0%)</td>
<td>83 (43.5%)</td>
</tr>
<tr>
<td>MAT allowed but with restrictions/reservations.</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>1 (3.3%)</td>
<td>0 (0.0%)</td>
<td>3 (3.0%)</td>
<td>18 (10.4%)</td>
<td>35 (18.3%)</td>
</tr>
<tr>
<td>MAT allowed without any restrictions/reservations.</td>
<td>4 (11.4%)</td>
<td>3 (33.3%)</td>
<td>13 (43.3%)</td>
<td>8 (53.8%)</td>
<td>51 (51.5%)</td>
<td>78 (45.1%)</td>
<td>61 (31.9%)</td>
</tr>
<tr>
<td>MAT administered/monitored on site.</td>
<td>30 (85.7%)</td>
<td>5 (55.6%)</td>
<td>8 (26.7%)</td>
<td>5 (33.3%)</td>
<td>25 (25.3%)</td>
<td>39 (22.5%)</td>
<td>12 (6.3%)</td>
</tr>
</tbody>
</table>

Qualitative feedback provided additional insight into factors influencing the range in MAT tolerance observed across facilities:

(1) **Perceived Lack of Demand**: While EMS professionals reported an increase in opioid-related drug market activity and overdoses in the Kansas City metropolitan area; these individuals are not being seen within treatment settings. Several stakeholders reported that the vast majority of substance-related issues within treatment settings are focused on alcohol- and methamphetamine-related disorders. There appears to be a disconnect between use of emergency and/or medical services and use of formal substance use disorder treatment services by individuals with opioid use disorder.

(2) **Zero Tolerance Philosophy**: Abstinence-only approaches to substance use disorder treatment typically exclude use of MATs. Several services based in this philosophy reported reasons like the following examples: “we do not allow any narcotics use; we have a zero tolerance policy” and “it is hard to tell narcotic use levels with a UA.”

(3) **Enduring Stigma of MATs**: Stigma of MATs persists for many service providers who report bad experiences with clients using methadone to maintain recovery from opioid use disorder. This stigma results in decisions that range from “based on experience with people of MATs, we do not accept them” to “it depends on the situation; we have had bad experiences with methadone and suboxone” because “clients on these act as if they are actively high”. However, this stigma appears to be shifting with injectable treatment like Vivitrol. For example, several providers explained that “Vivitrol is okay, but methadone and suboxone are problematic.”
(4) **Lack of Resources to Support Clients Using MATs**: Larger non-profit providers who operated within an integrated health model, described unconditionally supporting clients on MATs. These agencies had coordinated services across the SUD continuum of care, including on-site psychiatrists eligible to prescribe MATs. However, smaller agencies that focused on lower levels of care described having limited resources to handle the needs of clients on MATs. One agency explained that they only started accepting clients using MATs when “the methadone clinic [recently] became open 7 days a week.”

**Service Gaps: Assessment & Recommendations**

(1) **Strengthening collaborations between first responders and treatment providers.** Similar to our recommendations in Chapter 5, we recommend expanding programming that facilitates connections between first responders and treatment providers.

(2) **Increase capacity to identify and engage individuals most at risk for opioid-related overdose and deaths.** The continuum of care was still trying to find creative ways to identify populations at highest risk for opioid-related overdoses and deaths and to engage these individuals into treatment when they are identified. We identified several recommendations that may serve as a starting point:
   a. Promote policies and practices that help to minimize nonmedical use of prescription medications, such as interstate tracking of prescribed opioids and minimizing use of prescription opioids to treat chronic pain.
   b. Fund and promote prevention efforts focused on minimizing diversion of prescription medications and on deterring adolescent misuse of prescription medications. It may fruitful to target outreach efforts in communities of color where we are observing a spike in the rate of opioid overdose deaths.
   c. Continue to promote education about, access to, and use of NARCAN (naloxone HCl) nasal spray. Providers who are unfamiliar with this product can seek training resources from: [https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio](https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio)
   d. Utilize other harm reduction strategies to engage clients whose readiness for change may be low. For example, traditional 12-step, abstinence only methods may deter clients from engaging in treatment that can help them explore options regarding safe detoxification, medication assisted treatment, and steps towards long-term recovery. Harm reduction methods (focused on decreasing use and safer injection practices) combined with motivational interviewing can serve as a starting point for individuals to explore alternatives to their current practices (Redd, Seth, David, & Scholl, 2016).

(3) **Address the impact of opioid-related overdoses and deaths on family members.** Providers and community members should consider developing specialized services (both formal services and mutual aid groups) to address the needs of families impacted by opioid-related overdoses and deaths.
(4) Build capacity for outpatient and recovery services to address the needs of clients with opioid-related disorders. It appears that initiatives to fund and support the prescription and access of medication assisted treatment (MAT) have created a network of providers who are open to working with clients using MATs within high intensity treatment settings. However, more work still needs to be done to support providers within less intensive services and recovery settings who feel that they do not have adequate infrastructure or resources to address the needs of clients with MATs. We provide several recommendations as a starting point:

a. Providers should seek education about the benefits and challenges of medication-assisted treatment. Mid-America ATTC (http://attcnetwork.org/regional-centers/?rc=midamerica) is a regional resource that sponsors online and in-person trainings, disseminates resources, and helps other develop curriculum. For example, the KC Perinatal Recovery Collaborative is working to coordinate systems of care specializing in services for PPW diagnosed with substance use disorders.

b. Create and leverage existing resources that can support less intensive treatment and recovery services to effectively address the needs of this population. In addition to funders and policy makers creating funding mechanisms that equally focus on developing programming for outpatient and recovery services oriented to the needs of clients diagnosed with opioid use disorders, providers of these services can leverage current resources to help them develop innovative programming. For example, the STR-TA Consortium (https://getstr-ta.org/Index.aspx) provides technical assistance for a range of professionals interested in creating services address opioid-related prevention, treatment, and recovery services. The STR coordinator works to develop an action plan and to connect professionals to expert consultants that can help them realize their goals.

c. Increase partnerships between less intensive treatment/recovery providers and OTPs/trained psychiatrists.
CHAPTER 7. SERVICE-SPECIFIC AVAILABILITY AND CAPACITY

Introduction

The purpose of this chapter is to provide two page highlights for each *type of service* identified by our study across the substance use disorder (SUD) continuum of care. We observed a variety of strengths and gaps for services at each level of care; however, service-specific gaps often varied from the broader overview of the entire service sector. For example, we will explore a need for recovery housing services for specific populations (i.e., women, families with children, etc.) across the Kansas City metropolitan area that was not evident in the more generalized description provided in Chapter 5.

How to Use Service-Specific Data

It is important to remember that many agencies provide services across multiple facility locations and that these facility locations often provide more than one service. Service-specific data allows for an in-depth look at needs within a specific level of care or type of recovery support; however, it tells us very little about coordination of efforts across service levels. That being said, stakeholders within the recovery sector often described the importance of partnerships and/or being connected to treatment services in the advent that a client relapses or needs additional supports. They explained that these interagency connections facilitated ease of access to care when clients needed to level up (or down) service intensity.

Focusing on specific strengths and gaps for each service type can provide insights into the unique needs that each level of care may face. For example, we observed a large capacity within the outpatient sector; however, private, for-profit agencies that accepted cash or private insurance only comprised the majority of this level of care. This suggests a unique need to expand *affordable* outpatient services for moderate- to low-income individuals specifically. Alternatively, we observed that mutual aid groups are more geographically accessible across the metropolitan area than formal treatment services, and over 65% of these groups were recovery groups based in twelve step philosophy. In addition, accessibility has been expanded for these free, mutual aid groups through web-based formats. This use of technology can be particularly helpful in addressing the lack of anonymity many individuals feel when seeking place-based supports in less populated areas.

We organized this chapter so that the highlights specific to each service type are described on two pages (front and back) for ease of creating a 1-page handout. These can be distributed to any interested groups for further discussion or brainstorming about how this information may be relevant to your individual agency or facility. If you are curious about learning more about any specific service sector, please reach out directly to the principal investigator of this study: Nancy Jo Kepple, Ph.D., M.S.W. via e-mail at njkepple@ku.edu or via telephone at (785) 864-0147.
DETOXIFICATION SERVICES

Description

Detoxification services focus on addressing the withdrawal symptoms associated with the reduction or termination of using a psychoactive substance; all levels of care are capable of providing detoxification support depending on the client’s needs (Center for Substance Abuse Treatment, 2006; McNece & DiNitto, 2012). This section highlights facilities reporting provision of medical detoxification and outpatient detoxification in addition to exploring geographic availability and capacity of these services.

Highlights

A total of 35 facilities reported providing detox services (% medical, % outpatient). Medical detox capacity ranged from 16 beds to 105 beds; all sites reported no waitlist for these services. Several medical detox facilities reported that bed capacity was variable due to sharing bed with the ER and inpatient services. In addition, these services were geographically clustered around the Kansas-Missouri state line.

Figure 7A.1: Detox Facilities by Bed Capacity, Overlaid on Detoxification Enrollment
Towards a More Responsive Substance Use Disorder Continuum of Care: Kansas City Metropolitan Area 2018 Community Needs Assessment

Several detox facilities specialized in addressing withdrawal from specific psychoactive substances. For example, two of the nine medical detox sites reported only addressing detoxification form alcohol and benzodiazepines; they did not address opioid-related detoxification needs. (See Table 7A.1 for further details.)

Table 7A.1: Detoxification Services by Type of Psychoactive Substance

<table>
<thead>
<tr>
<th>Psychoactive Substance</th>
<th>% Medical Detox Facilities (n = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>9 (100.0%)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>5 (55.5%)</td>
</tr>
<tr>
<td>Opioids</td>
<td>7 (77.8%)</td>
</tr>
<tr>
<td>All Qualified Substances</td>
<td>4 (44.4%)</td>
</tr>
</tbody>
</table>

A total of 35 facilities reported providing detoxification services. All identified are predominantly secular. Approximately 52% reported being a part of a private, non-profit agency; 46% reported being a part of a private, for profit agency; and only 1 reported being a part of government-run agency. Approximately 75% of the facilities reported accepting Medicaid or Medicare, helping to make these services financially accessible.

Figure 7A.2: Proportion of Detox Services Providing MAT Treatment (N = 35)

Service Gaps: Assessment & Recommendation

Assessment. While medical detoxification capacity is limited, facilities are reporting little to no wait time for admittance, suggesting sufficient capacity. However, these services are geographically clustered. As a result, physical accessibility of these services are variable depending on the client’s county of origin.

Recommendation. At minimum, expanding outpatient-based detoxification services in less populated counties may help to increase access to treatment.
INPATIENT SERVICES

Description

For the purposes of this study, we defined inpatient services as highly controlled treatment environments with 24-hour medically managed or monitored care (ASAM, 2018). This section highlights geographic availability and capacity of inpatient services offered by facilities across the 10 county region.

Highlights

We identified 9 inpatient facilities that were in operation and accepting clients during the time of the study. The average capacity was 47 beds (ranging from 8 to 105 beds). Figure 7B.1 shows a geographic mismatch between the need for high level of care services (defined by high rates of substance-related deaths) and facility locations and capacity. Counties with higher rates of substance-related deaths, such as Leavenworth and Ray counties, had no services available to the general public (given the one facility in Leavenworth is run by the Veteran's Affairs).

Figure 7B.1: Inpatient Facilities by Bed Capacity and Overlaid on Substance-related Deaths
All inpatient facilities accepted private insurance; seven (78%) accepted Medicaid and four (44%) accepted Medicare. In addition, discharge services were standard practice across all inpatient settings; however, only two facilities reported providing structured case management services. All services reported currently having no wait time when we contacted them; although, they reported waitlists can vary over the course of the year.

Several of the facilities also provided services targeted to meet the needs of specific populations. Table 7B.1 breaks down the number of facilities providing specialized care by population type. Facilities serving adolescent populations were are separate locations from those serving adult services. Two of the adult-serving facilities reporting having specialized care for senior adults. All facilities reported accepting clients who identified as male, female, transgender, or nonbinary. All facilities that reported the capacity to provide medication assisted treatment for opioid use disorder served adult populations; facilities reported hesitancy using medication assisted treatment with adolescent populations.

### Table 7B.1: Inpatient Services Providing Specialized Care

<table>
<thead>
<tr>
<th>Target Population</th>
<th>% Inpatient Facilities (n = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents</td>
<td>3 (33.3%)</td>
</tr>
<tr>
<td>Adults</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>Senior Adults</td>
<td>2 (22.2%)</td>
</tr>
<tr>
<td>Individuals with Children</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Veterans</td>
<td>2 (22.2%)</td>
</tr>
<tr>
<td>Dually Diagnosed MH + SUD</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>Opioid-related Needs</td>
<td>6 (66.7%)</td>
</tr>
</tbody>
</table>

**Service Gaps: Assessment & Recommendation**

**Assessment.** Although we only identified less than 10 inpatient facilities, the lack of wait lists suggests sufficient capacity for the number of individuals seeking services. In addition, these services predominantly addressed both mental health and substance use disorder treatment needs. Given the small number of sites, the diversity of populations being served by these facilities is impressive and addressed the needs across the lifespan. That being said, it is important to note that these facilities are not equally accessible to everyone across the 10 county region due to geographic clustering and due to variability in payment options that they accept.

**Recommendation.** While it may not be logistically feasible to set-up an inpatient facility within lower density county areas, stakeholders may want to explore setting up systems to assist in referral and transport from front-line providers identifying client needs for inpatient services.
RESIDENTIAL SERVICES

Description

For the purposes of this study, we defined residential services as highly controlled treatment environments with 24-hour clinically managed residential services (ASAM, 2018; McNeece & DiNitto, 2012). This section highlights geographic availability and capacity of inpatient services offered by facilities across the 10 county region. In addition, we explore the availability of gender-specific services, supports of individuals with children in their care, and adolescent-specific services.

Highlights

We identified 30 residential facilities that were in operation and accepting clients during the time of the study. The average capacity was 47 beds (ranging from 2 to 398 beds). Figure 7C.1 shows a geographic mismatch between the need for high level of care services (defined by high rates of substance-related deaths) and facility locations and capacity.

Figure 7C.1: Inpatient Facilities by Bed Capacity and Overlaid on Substance-related Deaths
Towards a More Responsive Substance Use Disorder Continuum of Care: Kansas City Metropolitan Area 2018 Community Needs Assessment

While the number of facilities and capacity is higher than observed for detoxification or inpatient facilities, length of stay within these facilities is considerably longer (6 to 18 months) which results in 88% of facilities reporting near full capacity with wait lists of anywhere from a week to several months. Stakeholder interviews reflected that the primary gap in services typically occurs when individuals are moving from medical detoxification or hospital inpatient settings into residential care settings. When residential services are not available, clients often are referred to intensive outpatient services (even when their recovery supports and housing stability within the community is lacking). Only 8 (27.6%) of the residential facilities had the capacity to administer or monitor MAT treatment on site; however, an additional 13 (43.3%) facilities were unconditionally open to serving clients who were actively using MATs to treat their opioid use disorder. Approximately 93% of the residential facilities reported provision of at least 1 social service, aligning with NIDA recommendations for individualized, comprehensive care (NIDA, 2018).

**Figure 7C.1: Residential Facilities by Gender-specific Services**

Figure 7C.2 shows the residential sites by gender-specific services. Facilities specific to women or men only reported not accepted clients who identified as transgender. However, transgender identity did not prohibit individuals from receiving services within coed facilities. Of the facilities serving women only, four facilities allowed women to have children in their care, and three facilities specialized in serving pregnant and post-partum women. These facilities were geographically clustered in Northeast Jackson County. Facilities serving men only or coed populations did not allow children to reside with their parents. Finally, 24% residential facilities provided specialized programming for adolescent populations.

**Service Gaps: Assessment & Recommendation**

**Assessment.** We observed multi-dimensional services being provided at this level of care, in accordance with best practices and potentially driving the high demand. However, residential treatment capacity is limited (particularly for populations such as parents with children) and in high demand as evidence by wait lists.

**Recommendation.** Intensive outpatient services can provide treatment alternatives for populations seeking intensive treatment; however, intensive outpatient services cannot always address instability in recovery supports and housing faced by some individuals in recovery. Expansion of residential treatment capacity would likely benefit clients requiring more controlled environmental settings during early stages of recovery.
PARITAL HOSPITALIZATION/DAY TREATMENT SERVICES

Description

This level of care provides 20 or more hours of services per week for individuals who require intensive, multi-dimensional services but do not require 24-hour care (ASAM, 2018). This section highlights key findings that we observed specific to partial hospitalization or day treatment services.

Highlights

Fifteen facilities reported having partial hospitalization or day treatment services, and they were clustered in Clay County, MO, Jackson County, MO and Johnson County, KS.

Figure 7D.1: Partial Hospitalization/Day Treatment Facilities Overlaid on County Population
All facilities provided multiple services in addition to partial hospitalization or day treatment services. For example, all 15 sites provided intensive outpatient services and/or traditional outpatient services. In addition, 12 (80%) out of the 15 facilities were a part of large, multi-site agencies. For example, one large non-profit agency uses their day treatment site to provide treatment support for the clients residing in the agency’s recovery-oriented housing. This agency coordinates transportation between the housing and day treatment sites. Affordable options appear to be available but more limited than more intensive services with approximately 53.3% of facilities accepting Medicaid or Medicare.

Table 7D.1 shows the special populations served by these facilities. The vast majority address the needs of clients who have a dual diagnosis. It is important to note that at least three of these facilities specialized in mental health needs and explicitly stated that they would not treat SUD-related needs without a corresponding mental health diagnosis.

Forty percent of the facilities had providers who could administer or monitor MAT treatment on site. In addition, 87% of facilities reported they would accept clients actively using MATs without reservation. Stakeholders described having sufficient infrastructure and medical support within these facilities to navigate the client needs.

Table 7D.1: Partial Hospitalization/Day Treatment Services Providing Specialized Care

<table>
<thead>
<tr>
<th>Target Population</th>
<th>% Facilities (n = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents</td>
<td>6 (40.0%)</td>
</tr>
<tr>
<td>Women with Children</td>
<td>1 (6.7%)</td>
</tr>
<tr>
<td>Pregnant/Post-Partum Women</td>
<td>1 (6.7%)</td>
</tr>
<tr>
<td>Veterans</td>
<td>3 (22.2%)</td>
</tr>
<tr>
<td>Dually Diagnosed MH + SUD</td>
<td>12 (80.0%)</td>
</tr>
<tr>
<td>Opioid-related Needs</td>
<td>6 (40.0%)</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>4 (26.7%)</td>
</tr>
</tbody>
</table>

Service Gaps: Assessment & Recommendation

**Assessment.** This level of care appears to be focused primarily on addressing mental health needs and to target clients who are dually-diagnosed. While the majority of facilities reported not being able to specifically address opioid-related treatment needs, this did not prevent MAT-using clients with co-occurring mental health and opioid use disorders from receiving services. Second, affordable services for low-income individuals was more limited compared to higher levels of care. Finally, we did not obtain information on wait lists for these sites and cannot speak to their availability. However, we did identify that several agencies used their day treatment services in coordination with their residential support services rather than as a stand-alone service.

**Recommendations.** As an alternative to residential treatment services, providers may want to explore expanding the availability of partial hospitalization or day treatment services for individuals seeking treatment primarily for substance use disorders.
INTENSIVE OUTPATIENT SERVICES

Description

Intensive outpatient (IOP) services are defined by 9 or more hours of service per week (6 hours or more for adolescents) to treat clients with intensive, multi-dimensional services but may have stable home or living situations that allow them to safely reside in the community (ASAM, 2018). This level of care is effective to serve individuals who require high intensity services but have stable community supports and housing.

Highlights

The availability and number of intensive outpatient services was greater than higher levels of care. We observed a presence of facilities across all 10 counties. That being said, services accepting Medicaid continued to be clustered within the more urbanized county areas. The increased availability of facilities was primarily driven by an increase in private, for profit facilities providing these services, which accounted for approximately half of IOP services. Figure 7E.1 shows IOP facility locations by Medicaid acceptance.

Figure 7E.1: Distribution of Intensive Outpatient Services Categorized by Medicaid Acceptance
Towards a More Responsive Substance Use Disorder Continuum of Care: Kansas City Metropolitan Area 2018 Community Needs Assessment

Approximately three-quarters of facilities reporting a secular orientation. However, we did observe about 15% of facilities reported having Christian-oriented services to address client treatment and recovery needs. This mirrored the number of facilities (83%) open to serving transgender or non-binary clients. Only about a quarter of facilities providing IOP services also reported prescribing or monitoring MATs on site. We would have expected a higher number of facilities reporting MAT services given best practice models for IOP encourage use of MATs and active drug testing to address the fact that clients are actively engaging with their communities and are not being treated within a controlled environment (Center for Substance Abuse Treatment, 2006). This discrepancy may be due to few programs implementing evidence-based IOP models for treatment of substance use disorders, like the Matrix Model.

Compared to higher levels of care, we observed a larger proportion of these services being supported and targeted towards clients within the criminal justice system. Several stakeholders reported that their primary referral source was the Department of Justice and that they were contracted to provide intensive services for clients who had been court-ordered into a diversion program for alcohol and/or other drug-related criminal activity.

Table 7E.1: Intensive Outpatient Services Providing Specialized Care

<table>
<thead>
<tr>
<th>Target Population</th>
<th>% IOP Facilities (n = 99)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents</td>
<td>37 (37.4%)</td>
</tr>
<tr>
<td>Pregnant/Post-Partum Women</td>
<td>7 (7.1%)</td>
</tr>
<tr>
<td>Veterans</td>
<td>5 (5.1%)</td>
</tr>
<tr>
<td>Dually Diagnosed MH + SUD</td>
<td>38 (38.4%)</td>
</tr>
<tr>
<td>Opioid-related Needs</td>
<td>26 (26.3%)</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>40 (40.4%)</td>
</tr>
</tbody>
</table>

Service Gaps: Assessment & Recommendation

Assessment. The availability and geographic accessibility of IOP services is higher than more intensive levels of care. This increase in number of providers allows for a diversification in the specialized services available. That being said, their affordability may be limited based on the availability is primarily due to increase in private, for profit providers. Many of these private, for profit providers are serving clients referred directly from the Department of Justice. In addition, few IOP services are following best practice models for treating substance use disorders at this level of care.

Recommendation. While service availability is high, the availability of affordable services likely needs to be expanded. In addition, IOP models should consider using best practices for substance use treatment at the IOP level that incorporate individual and group counseling, family education, alumni supports, drug testing, and facilitation of MAT use for clients with opioid use disorders (Center for Substance Abuse Treatment, 2006).
TRADITIONAL OUTPATIENT SERVICES

Description

Traditional outpatient services are defined by 9 or less hours of service per week (6 hours or less for adolescents) to address clients with less intensive treatment needs, or for clients not ready to engage in more intensive levels of care (ASAM, 2018; McNeece & DiNitto, 2012).

Highlights

Similar to IOP services, the availability of services was highest at this level of care. We observed a presence of facilities across all 10 counties. Approximately 45% of these agencies reported being a private, for-profit organization. In addition, less than 50% of these facilities reported a primary focus on treating substance use disorders. Ninety-four (53%) of the 178 identified facilities accepted Medicaid. Figure 7F.1 show the distribution of facilities across the 10 county region by Medicaid acceptance.

Figure 7F.1: Traditional Outpatient Services Categorized by Medicaid Acceptance
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Only 9% of facilities reported having Spanish-speaking staff, and 22% of facilities reporting using on-call interpreters who spoke Spanish. These statistics were reflected in stakeholder feedback describing limited outpatient services available for Spanish-speaking clients. The only specialized services for LGBTQIA+ populations in the Kansas City area reported providing outpatient services through private practitioners.

### Table 7F.1: Proportion of Outpatient Facilities by Age Group of Clients Served

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% Facilities (n = 178)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child (ages 5 to 10)</td>
<td>32 (18.0%)</td>
</tr>
<tr>
<td>Adolescents (ages 11 to 17)</td>
<td>114 (64.0%)</td>
</tr>
<tr>
<td>Adults (ages 18 to 64)</td>
<td>160 (89.9%)</td>
</tr>
<tr>
<td>Older Adults (ages 65+)</td>
<td>157 (88.2%)</td>
</tr>
</tbody>
</table>

Approximately 44% of the facilities reported accepting clients using MATs for opioid use disorder without any reservations. Another 22% of the facilities have a provider who can administer or monitor MATs on site. Stakeholder feedback highlighted that having adequate training and/or the support of psychiatric staff on site helped them to be open to accepting clients using MATs to address their opioid use disorder. Another provider highlighted how medication use can be a helpful treatment: “The women on MATs do well here. They seem to really want to make a change for the better.” In contrast, the practitioners who had reservations about serving clients using MATs or did not accept clients with opioid use disorder described “following traditional 12-step model ... does not allow for narcotics use” or “lack of training to adequately treat opioid use disorders” resulting in providers “referring out if MAT needs are present.” One provider explained, “I had mixed experiences with clients in the past, and I do not have a full understanding of what MATs are.”

### Service Gaps: Assessment & Recommendation

**Assessment.** The availability and geographic accessibility of traditional outpatient services is highest compared to all other levels of care. This increase in number of providers allows for a diversification in the specialized services available, including specialized services across the lifespan and for underserved populations, such as individuals identifying as a part of the LGBTQIA+ community. That being said, their affordability may be limited based on the availability is primarily due to increase in private, for profit providers, and very few providers reported ability to provide services in non-English languages. In addition, less than half of these facilities reported willingness or capacity to service clients using MATs for opioid use disorders.

**Recommendation.** While service availability is high, the availability of affordable services likely needs to be expanded. Outpatient service providers may need to build capacity through training and partnerships to expand access for specific populations, such as individuals who are Spanish-speaking or those diagnosed with opioid use disorder.
PREVENTION, SCREENING, & EDUCATION SERVICES

Description

These services are for individuals who, for a known reason, are at risk of developing substance-related problems, or a service for those for whom there is not yet sufficient information to document a diagnosable substance use disorder (ASAM, 2018).

Highlights

A total of 229 facilities reported screening, education services, or prevention programming. The vast majority of facilities providing this level of care reported a focus on screening and education services (n = 225). Within agencies focusing on mental health or substance use treatment, these screening and education services were typically adjunctive to the main treatment focus. Within these agencies, we observed approximately 5% of facilities explicitly implementing Screening, Brief Intervention, & Referral to Treatment (SBIRT) procedures.

FIGURE 7G.1: Facility Locations for Screening, Education, and Prevention services
Providers accepting clients referred by the Department of Justice reported education-oriented services that were court mandated for individuals charged with a DUI or other substance-related offenses. In fact, 23% of these services reported a focus on clients referred from Substance Awareness Traffic Offender Program (SATOP) in Missouri or the equivalent DUI diversion programs in Kansas.

Prevention programming included primary, secondary, and tertiary programming. Primary prevention programs composed less than 10% of all services. Not surprisingly, these primary prevention programs were typically community-based, where agency representatives worked within schools or other community locations where they identified a high-risk population (making it difficult to map geographic coverage). In addition, primary programs typically focused on prevention of substance misuse among children and adolescents. Government funds or private grants typically covered the cost of these services, making them free to recipients. However, stakeholders described how many of these programs are dependent upon time-limited grants, making it difficult to sustain prevention programs over time.

Table 7G.1: Proportion of Prevention Facilities Serving Specific Population

<table>
<thead>
<tr>
<th>Population Group</th>
<th>% Prevention Programs (n = 89)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child (ages 5 to 10)</td>
<td>22 (24.7%)</td>
</tr>
<tr>
<td>Adolescents (ages 11 to 17)</td>
<td>62 (69.7%)</td>
</tr>
<tr>
<td>Parenting Families</td>
<td>12 (13.5%)</td>
</tr>
<tr>
<td>Pregnant and Post-Partum Women</td>
<td>2 (2.2%)</td>
</tr>
</tbody>
</table>

Table 7G.1 show that a relatively small proportion of prevention programs focused on reducing substance misuse with pregnant and post-partum women or parents with children under the ages of 18 years old. These interventions not only focus on helping the parents but also minimizing child-related harms. Early engagement may help to prevent parental substance misuse from escalating into substance use disorder; and associated problematic parenting (Kepple, 2017).

Service Gaps: Assessment & Recommendations

**Assessment:** We observed several facilities explicitly implementing SBIRT procedures; however, we were expecting a larger proportion of services to be using these procedures. The proportion of services providing primary prevention is relatively low, and these programs were typically located within schools.

**Recommendation:** The continuum of care could benefit from increasing the use of these practices to increase identification and engagement of high-risk clients into services. The sector could benefit from investing in primary prevention to address high-risk behaviors before they escalate into substance use disorder and contribute to significant substance-related harms. For example, programs targeting high-risk parenting populations can minimize substance-related harms to children.
RECOVERY SERVICES

Description

We defined recovery services include services that focus on stabilizing individuals within the community during or after treatment and promoting long-term recovery. Individuals in recovery are often at their most vulnerable after they leave treatment. For example, people with opioid dependence are at the highest risk of overdose following reduced tolerance, arising from detoxification, release from incarceration, or completion of substance use disorder (SUD) treatment (World Health Organization, 2014). Recovery supports help to minimize likelihood of relapse and include recovery coaching, recovery housing, and recovery management through check-ups or telephone case monitoring, recovery community centers, and recovery-based education.

Highlights

Figure 7H.1 shows the geographic distribution of housing options for clients in recovery, and Table 7H.1 shows the breakdown of the type of recovery services in the Kansas City metropolitan area.

Figure 7H.1: Geographic Distribution of Recovery Options by Type of Housing Services*

* Locations with protected addresses were geocoded to an approximate location within surrounding zip codes.
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Table 7H.1: Recovery Services by Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>% Recovery-Oriented Facilities (n = 196)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>128 (65.3%)</td>
</tr>
<tr>
<td>Men Only</td>
<td>61 (47.7%)</td>
</tr>
<tr>
<td>Women Only</td>
<td>39 (30.5%)</td>
</tr>
<tr>
<td>Women or Men with Children</td>
<td>38 (29.7%)</td>
</tr>
<tr>
<td>Coed</td>
<td>28 (21.9%)</td>
</tr>
<tr>
<td>Accept Clients identifying as Transgender</td>
<td>19 (14.8%)</td>
</tr>
<tr>
<td>Recovery Care</td>
<td></td>
</tr>
<tr>
<td>Care Coordination/Therapeutic Aftercare</td>
<td>77 (39.3%)</td>
</tr>
<tr>
<td>Peer Support or Peer Navigators</td>
<td>88 (44.9%)</td>
</tr>
<tr>
<td>Recovery Coaching</td>
<td>38 (19.4%)</td>
</tr>
<tr>
<td>Recovery Community Center/Space</td>
<td>4 (2.0%)</td>
</tr>
</tbody>
</table>

We identified 128 out of the total 196 recovery-oriented facilities provided transitional housing for individuals in recovery from alcohol and other drug use disorders. This accounts for almost a third of the facilities identified in the community needs assessment. That being said, the vast majority of facilities reported having such a high demand that they did not keep a waitlist and instead asked people to call back on a regular basis to check for openings. The number of facilities significantly decreased when we factor in special population needs. For examples, parents who are seeking recovery housing that will allow their children to reside with them face even longer wait times and limited options. This number dwindles to zero within the Kansas counties when we looked at recovery-specific housing for women (or men) with children who also are currently using medication-assisted treatment. These families typically were referred to general emergency shelters. Other recovery services that stakeholders reported were helpful, but limited, include peer navigators and dedicated recovery community centers. Funding promoting these services can help to increase the likelihood of individuals transitioning into long-term recovery and minimizing the likelihood of relapse.

Service Gaps: Assessment & Recommendations

**Assessment:** Recovery services (not including mutual aid groups) were in demand and at capacity; stakeholders described a desire for more financial supports and resources to help build a comprehensive recovery system of care. Based on wait lists, we are severely lacking available housing options, especially for those identify as women or men with children in their care, clients using MATs, and/or LGBTQIA+.

**Recommendations:** We recommend strengthening the recovery-oriented systems of care that includes linkages to outpatient services, recovery housing, and recovery coaching or management check-ups (NIDA, 2018). In addition, investment in recovery community organizations (RCOs) (Valentine, White, & Taylor, 2007) can address multi-level recovery needs through providing a safe physical space for socialization, building a strong recovery community, engaging community members in meaningful activities, and facilitating access to resources and peer advocates (see CCAR website for an example model at [http://ccar.us/recoverycnters.htm](http://ccar.us/recoverycnters.htm)).

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MUTUAL AID GROUPS

Mutual aid groups provide an affordable and long-term source of support for individuals in recovery. Family support programs assist families who are seeking information, understanding, and support in navigating their loved ones’ substance use disorders.

**12-Step Formats**

<table>
<thead>
<tr>
<th>12-Step Formats</th>
<th>Other Popular Formats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas City Specific:</td>
<td>Smart Recovery <a href="https://www.smartrecovery.org/">https://www.smartrecovery.org/</a></td>
</tr>
<tr>
<td>AA Online: <a href="http://www.aaonlinemeeting.net/">http://www.aaonlinemeeting.net/</a></td>
<td></td>
</tr>
<tr>
<td>NA <a href="https://www.na.org/">https://www.na.org/</a></td>
<td></td>
</tr>
<tr>
<td>Kansas City Specific:</td>
<td>Al-Anon <a href="https://al-anon.org/">https://al-anon.org/</a></td>
</tr>
<tr>
<td><a href="http://www.kansascityna.org/">http://www.kansascityna.org/</a></td>
<td></td>
</tr>
<tr>
<td>NA Online: <a href="http://www.na-recovery.org/">http://www.na-recovery.org/</a></td>
<td></td>
</tr>
<tr>
<td>MJA <a href="https://www.marijuana-anonymous.org/">https://www.marijuana-anonymous.org/</a></td>
<td></td>
</tr>
<tr>
<td>CA <a href="https://ca.org/about-ca/">https://ca.org/about-ca/</a></td>
<td></td>
</tr>
<tr>
<td>CMA <a href="https://crystalmeth.org">https://crystalmeth.org</a></td>
<td></td>
</tr>
<tr>
<td>Dual Recovery Anonymous</td>
<td>Nar-Anon <a href="http://www.nar-anon.org/">http://www.nar-anon.org/</a></td>
</tr>
<tr>
<td></td>
<td>Adult Children of Alcoholics: <a href="http://www.adultchildren.org/">http://www.adultchildren.org/</a></td>
</tr>
<tr>
<td></td>
<td>DualAnon <a href="http://dualanon.org/">http://dualanon.org/</a></td>
</tr>
</tbody>
</table>

Figure 7.1.1: Mutual Aid Groups Overlaid on Facility Count

Figure 7.1.1 shows how these recovery groups are geographically distributed across the 10 county region. Overlaid on existing formal services, we see these groups are likely serving as supplemental to (rather than replacement of) treatment and recovery services.

Table 7.1 breaks down the number of groups by type of model/format. These highlight the increasing number of online forums available to address potential issues with lack of

Table 7.1
anonymity for individuals living in lower density areas or lack of access to groups for individuals living in more remote areas.

We observed SMART Recovery groups to be predominantly within organizations and/or neutral community spaces. In contrast, we observed 12-Step and Celebrate Recovery groups to be predominantly within churches, community spaces, or sober living settings. In addition, we identified only two groups that identified as predominantly Spanish-speaking groups. Finally, stakeholder interviews identified a lack of family support groups focused on the specific needs of families affected by opioid-related overdoses and deaths.

Table 7I.1: Number and Proportion of Registered Mutual Aid Groups by Type

<table>
<thead>
<tr>
<th>Type of Registered Mutual Aid Group (N = 371)</th>
<th>Count</th>
<th>Percent</th>
<th>Online Formats Available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12-Step Formats</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholics Anonymous (AA)</td>
<td>170</td>
<td>45.8</td>
<td>*</td>
</tr>
<tr>
<td>Narcotics Anonymous (NA)</td>
<td>80</td>
<td>21.6</td>
<td>*</td>
</tr>
<tr>
<td>Marijuana Anonymous (MA)</td>
<td>1</td>
<td>0.3</td>
<td>*</td>
</tr>
<tr>
<td>Cocaine Anonymous (CA)</td>
<td>7</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Crystal Meth Anonymous (CMA)</td>
<td>3</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Dually Recovery Anonymous</td>
<td>4</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td><strong>Other Common Formats</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celebrate Recovery</td>
<td>19</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>SMART Recovery</td>
<td>13</td>
<td>3.5</td>
<td>*</td>
</tr>
<tr>
<td>Moderation Management</td>
<td>0</td>
<td>0.0</td>
<td>*</td>
</tr>
<tr>
<td><strong>Family Support Groups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AlAnon</td>
<td>54</td>
<td>14.6</td>
<td>*</td>
</tr>
<tr>
<td>Alateen</td>
<td>4</td>
<td>1.1</td>
<td>*</td>
</tr>
<tr>
<td>Adult Children of Alcoholics (ACOA)</td>
<td>5</td>
<td>1.3</td>
<td>*</td>
</tr>
<tr>
<td>NarAnon</td>
<td>4</td>
<td>1.1</td>
<td>*</td>
</tr>
<tr>
<td>Narateen</td>
<td>0</td>
<td>0.0</td>
<td>*</td>
</tr>
<tr>
<td>DualAnon</td>
<td>1</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>General Family Support</td>
<td>6</td>
<td>1.6</td>
<td></td>
</tr>
</tbody>
</table>

Service Gaps: Assessment & Recommendations

**Assessment.** Mutual aid groups provided the most affordable and accessible services within the continuum of care; however, these groups were predominantly driven by 12-step models. For individuals seeking alternative formats or formats with language-specific services, access to in-person meetings was highly limited.

**Recommendation.** Expansion of mutual aid group, such as SMART Recovery, is important for clients using harm reduction methods or actively using MATs, given 12-step formats predominantly support a philosophy of zero tolerance for narcotics use. Alternatively, 12-step format may want to explore how to support clients using MATs to address their opioid use disorders.
CHAPTER 8. SUMMARY OF STRENGTHS, GAPS, & RECOMMENDATIONS

Introduction

In this chapter, we synthesize the issues discussed throughout this report. We highlight the key areas of concern that we identified from the data, describing the associated service strengths, service gaps, and recommendations for next steps.

Key Areas of Concern

Key Area #1: The SUD continuum of care is strong but not enough to curb rising drug-related overdoses and deaths.

Assessment of Strengths & Gaps: We identified services that cover the full range of care from prevention to treatment to recovery supports; however, the current service availability and capacity is insufficient to ebb the tide of drug-related overdoses and deaths.

Recommendations:

- Invest in services, such as primary prevention and recovery services, that keep individuals healthy and living safely in the community.
- Establish partnerships between first responders and service providers to create better engagement into treatment.
- Establish partnerships between agencies, or development of more services that specifically address the service gaps that arise from extensive waitlists for clients as they step down to less intensive levels of care (e.g., detox/inpatient → residential facilities; residential facilities → recovery housing).

Key Area #2: The substance-related risks are high in rural counties, yet service density is low.

Assessment of Strengths & Gaps: While we observed a need for services in less urbanized counties, stakeholders cautioned that addressing rural community needs likely is not as easy as transplanting addiction models that work for urban environments. For example, it may not be financially viable to support a satellite office within a rural county where clients would still be required to travel far distances. Some private outpatient providers reported that they have begun to explore telemedicine to address these concerns. Alternatively, recovery housing that are remote from adjunctive counseling, employment, and other support services may increase hardships for residents.
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Recommendations:

- Continue exploring expansion of telemedicine services.
- Use of alternative strategies, such as peer recovery mentors or promotion of other low-cost solutions such as online recovery support groups, may provide short-term solutions to address immediate needs for individuals residing in these less dense communities.
- Develop new geographically-appropriate models to address specific needs of individuals residing in less dense environments who are misusing substances.

Key Area #3: Build capacity for services to effectively address the needs of individuals at-risk of, in need of treatment for, and in recovery from opioid use disorder.

Assessment of Strengths & Gaps: The continuum of care is still trying to find creative ways to identify populations at highest risk for opioid-related overdoses and deaths and to engage these individuals into treatment when they are identified. In addition, we have observed the rate of opioid overdose deaths is disproportionately affecting clients who were identified as Black/African American within the past 5 years. This disparity suggests a need to target prevention and treatment engagement efforts within communities of color to ensure the SUD continuum of care adequately addressed these communities’ needs. Finally, initiatives to fund and support the prescription and access of medication assisted treatment (MAT) have created a network of providers who are open to working with clients using MATs within high intensity treatment settings. However, more work still needs to be done to support facilities providing less intensive and recovery services who feel that they do not have the infrastructure or resources for clients using MATs.

Recommendations for Addressing Opioid-Related Risk:

- Promote policies and practices that help to minimize nonmedical use of prescription medications, such as interstate tracking of prescribed opioids and minimizing use of opioids to treat chronic pain.
- Partner with natural helpers within communities of color, low-income communities, and other communities that may not be actively engaging in treatment services.
- Fund and promote prevention efforts focused on minimizing diversion of prescription medications and on deterring adolescent misuse of prescription medications.
- Continue to promote education about, access to, and use of NARCAN (naloxone HCl) nasal spray. Providers who are unfamiliar with this product can seek training resources from: https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio
- Utilize other harm reduction strategies to engage clients whose readiness for change may be low. For example, traditional 12-step, abstinence only methods may deter clients from engaging in treatment that can help them explore options regarding safe detoxification, medication assisted treatment, and steps towards long-term recovery. Harm reduction methods (focused on decreasing use and safer injection practices) combined with motivational interviewing can serve as a starting point for individuals to explore alternatives to their current practices.
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Recommendations for Addressing Opioid-Related Treatment and Recovery Needs:

- Providers should seek education about the benefits and challenges of medication assisted treatment. Mid-America ATTC (http://attcnetwork.org/regional-centers/?rc=midamerica) is a regional resource that sponsors online and in-person trainings, disseminates resources, and helps other develop curriculum. For example, the KC Perinatal Recovery Collaborative is working to coordinate systems of care specializing in services for PPW diagnosed with substance use disorders.
- Create and leverage existing resources that can support less intensive treatment and recovery services to effectively address the needs of this population. Funders and policy makers need to create funding mechanisms that equally focus on developing programming for outpatient and recovery services oriented to the needs of clients diagnosed with opioid use disorders. In addition, providers of these services can leverage current resources to help them develop innovative programming. For example, the STR-TA Consortium (https://getstr-ta.org/Index.aspx) provides technical assistance for a range of professionals interested in creating services address opioid-related prevention, treatment, and recovery services. The STR coordinator works to develop an action plan and to connect professionals to expert consultants that can help them realize their goals.
- Increase partnerships between less intensive treatment/recovery providers and OTPs/trained psychiatrists.

Key Area #4: The relative availability of services (and associated funding sources) for low-income populations is insufficient to address service demand.

Assessment of Strengths & Gaps: The number of available services were highest for clients who have sufficient financial resources of pay out-of-pocket for services, particularly for services such as intensive outpatient and traditional outpatient care. This is not the case for low-income populations who qualify for Medicaid, as suggested by Kansas practitioners reporting funds were depleted by the end of the third quarter. Affordability is likely a larger issue than we can assess here, given we did not specifically address the gap that exists for clients who do not qualify for Medicaid, have insufficient private medical coverage, and cannot afford to pay out-of-pocket.

Recommendation: Federal or state funding for SUD services should be increased to minimize previously documented disparity in treatment outcomes observed for low-income individuals and their families (Guerrero, Garner, Cook, Kong, Vega, & Gelberg, 2017).

Key Area #5: Recovery services are in demand and at capacity, especially for clients are seeking safe and stable housing options.

Assessment of Strengths and Gaps: Recovery services (not including mutual aid groups) were in demand and at capacity; stakeholders described a desire for more financial supports and resources to help build a
comprehensive recovery system of care. Based on the wait lists that we observed, the SUD continuum of care was severely lacking available recovery housing options, especially for those identify as women or men with children in their care, clients using MATs, and/or LGBTQIA+.

**Recommendations:**

- Strengthen the recovery-oriented systems of care that includes linkages to outpatient services, recovery housing, and recovery coaching or management check-ups (NIDA, 2018).
- Develop initiatives to support development of recovery housing, emphasizing the need for housing that supports clients using MATs, women or men with children, or clients identifying at LGBTQIA+. Along these lines, practitioners should consider developing specialized services for these populations that can address their unique needs and create inclusive, safe spaces.
- Investment in recovery community organizations (RCOs) (Valentine, White, & Taylor, 2007) can address multi-level recovery needs through providing a safe physical space for socialization, building a strong recovery community, engaging community members in meaningful activities, and facilitating access to resources and peer advocates (see an example model at [http://ccar.us/recoverycnters.htm](http://ccar.us/recoverycnters.htm)).

**Key Area #6: Build a Diverse Workforce to Create Inclusive, Language-Appropriate Services.**

**Assessment of Strengths & Gaps:** The SUD continuum of care lacked the capacity to serve non-English speaking populations. Providers reported a lack of sufficient work force to address the language needs of clients in the Kansas City metropolitan area. Even when we factored in reported use of on-call interpreters, only 20% of agencies reported being able to provide language-appropriate services for clients.

**Recommendations:**

- Increase use of on-call interpreters to address an immediate need.
- Recruit and train providers with a range of language skills will be essential to creating a more inclusive continuum of care.

**Key Area #7: Address the impact of opioid-related overdoses and deaths on family members.**

**Assessment of Strengths and Gaps:** The SUD continuum of care does not have an adequate support system for families who have lost children to opioid overdose deaths. Many times these individuals and their families may interface with emergency personnel or medical professionals but not be seen by providers along the SUD continuum of care. One provider explained that there was not a space that fits these families well; their experiences do not align with the many family support mutual aid groups available throughout the Kansas City metropolitan area. These families’ needs also are more specific than a general bereavement group can provide.
**Recommendation:** Providers and community members should consider developing specialized services (both formal services and mutual aid groups) to address the needs of families impacted by opioid-related overdoses and deaths.

**Conclusions**

While we highlighted opioid-specific needs in this report, we also want to emphasize that our community needs assessment showed a need across all communities related to all substances over the course of the lifespan. Treatment providers are still seeing a predominant need to address alcohol misuse, methamphetamine and other stimulant misuse, and particularly, poly-substance use. We hope that this information serves as a starting point for community stakeholders to move the Kansas City metropolitan area towards a more responsive SUD continuum of care.

As a resource, we updated two publicly available referral listings hosted by First Call Alcohol/Drug Prevention & Recovery using the information collected during the course of this needs assessment:

**Crisis Referral Hotline:** 816-361-5900

**Interactive Online Resource Guide:** [https://www.firstcallkc.org/resources](https://www.firstcallkc.org/resources)

If you have any questions about the community needs assessment, information in this report, or assistance in how to think about using this data to take the next steps, please contact Nancy Jo Kepple, Ph.D., M.S.W. at njkepple@ku.edu or (785) 864-0147.
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References


