Technology Assisted Care: Addressing the Barriers to SUD Treatment Faced by Consumers with Co-existing Disabilities


Substance Abuse Resources & Disability Issues (SARDI) Program

I. Introduction

The Technology Assisted Care (TAC) program was designed to address the barriers to Substance Use Disorder (SUD) treatment faced by consumers with co-existing disabilities in the Consumer Advocacy Model (CAM) Program. During the three year study, consumers (n=168) from across the state of Ohio received counseling and case management through a tele-health model. This model was intended to reduce barriers to treatment and improve accessibility for consumers with disabilities and Deaf consumers. Additionally, TAC consumers had a reduction in “no show” rates. The resulting change suggests that such accommodations can be as good for the organization as for the consumers.

II. Population

Those served include persons with disabilities with barriers to successful treatment (for example Deaf consumers, persons with developmental disabilities, traumatic brain or spinal cord injuries). Outreach and services were also provided to former military and their families, especially veterans where a service-related injury or other disability inhibited that person from fully benefiting from traditional SUD treatment. Consumers receiving TAC services reside in communities across Ohio. The current average distance of a TAC consumer from CAM is 66.59 miles, with the furthest consumer living 209 miles away, and the closest consumer living within one mile.

III. Accessible Resources (asynchronous)

Consumers are able to access resources in a variety of languages and formats, including video, audio, and text. As a CAM moves to an electronic health record (EHR), consumers will have increased direct access to their health information. The portals are designed to be flexible and adaptable to fit a variety of languages and consumer needs. As technology improves, a web based system allows the program to change and improve as technology improves. Electronic schedule reminders are also available via email and text for those individuals who choose to receive them.

CAM consumers who use American Sign Language (ASL) have access to specialized services in addition to the resources available in English. Increasingly, materials are available in ASL or with closed captioning for hard of hearing and late deafened consumers.

IV. Accessible Communication (synchronous)

TAC consumers have the ability to attend sessions with providers remotely or in person. In addition, they can communicate by text message, email, and phone. Each consumer’s needs are different and through technology they have the choice of utilizing as many or as few of these modes of communication as they see fit. Deaf consumers are also able to attend online 12-step meetings remotely in secure meeting rooms.

By providing opportunities for synchronous and asynchronous communication, the number of monthly contacts per consumer can increase without adversely increasing the workload for providers. This level of engagement is increasingly common in other areas as consumers continue to embrace technology in their lives. Communicating in these ways is not only convenient, but a reasonable accommodation for many. Tele-health provides a way for consumers with mobility or transportation issues to attend appointments they would otherwise miss. It also allows Deaf consumers a culturally and linguistically appropriate means of communicating with professionals in their own language and reduces the need for costly interpreting services in some cases.

V. Consumer Engagement

Consumer Contact

The program made every effort to meet consumers “where they are” in terms of technology, accessibility, and consumer preferences. More than 73% of consumer contacts were conducted remotely, and more than 83% of counseling contacts occurred through technology.

Appointment “No Show” Rate

TAC consumers were more likely to show up for scheduled appointments, with a “no-show” rate 10% lower than traditional consumers in the same facility, and higher rates of contact per month were reported.

VI. Results

Substance Use

Consumers who started the program with active alcohol use reduced the number of days of use significantly (p<0.001) after six months. Similarly, consumers who started the program with active illegal drug use also reduced the number of days of use significantly (p<0.038). It is believed that the increase in drinking four or fewer drinks in one sitting by illegal drug users is a result of users replacing their illegal drug use with alcohol use instead.

Mental Health

Consumers significantly reduced the number of days in which they reported serious depression (p<0.001), anxiety (p<0.001), and having trouble understanding or concentrating (p=0.026) after participating in the program for six months. There was also a marginal decrease (p=0.090) in the number of days consumers experienced hallucinations during the same time frame.

VII. Conclusions

The CAM program has developed a sustainability plan that will allow remote services to continue at the end of the funded project, and offers exciting possibilities for persons with disabilities who experience a number of risks which increase their chances for substance abuse and introduce barriers to receiving treatment. This sustainability is possible as a result of time and cost savings resulting from adoption of TAC methods for traditional consumers, and the cost of new technologies can be offset through reduced unproductive time for providers.

VIII. Acknowledgments

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