# Pathways to Recovery-Oriented Systems of Care and Overcoming Obstacles

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# Introduction

# Background

As estimated in 2007, addiction to substances costs the United States roughly $193 billion (National Drug Intelligence Center, 2011).

Treatment for addiction is known to reduce these costs with one Fortune 100 company saving a total of $500 per employee on healthcare (Miller & Flaherty, 2000).

Alcohol and drug dependence is best understood as a chronic illness (McLellan, Lewis, O'Brien, & Kleber, 2000).

Based on limits of the acute-care model to address chronic illness, multiple calls have been made to change the addiction treatment model

(McLellan, et al, 2000; White, Boyle, & Loveland, 2002; Godley, Godley, Dennis, et al, 2002; Dennis, Scott & Funk, 2003; McKay, 2005; Dennis, Scott, Funk, & Foss, 2005; Scott, Dennis, & Foss, 2005; Hser, Hamilton, & Niv, 2009; Dennis & Scott, 2012).

# Addiction Treatment and Recovery Service Models

## ACUTE-CARE MODEL

Has dominated substance use treatment to date

Effective at providing crisis management and stabilization

Brief treatment model focused on alleviating symptoms

Primary goal is abstinence

## RECOVERY-ORIENTED SYSTEMS OF CARE MODEL

An emerging model of care

Initial evidence for effectiveness at reducing costs to communities and increasing positive outcomes for clients

Defined by “networks of organizations, agencies, and community members that coordinate a wide spectrum of services…” (Sheedy & Whitter, 2013, p. 227).

Primary goal to support long-term recovery

# Current Gaps in Treatment

Limitations of the acute care model (White, 2008; White & Tuohy, 2013):

- Low rates of people (10%) with substance use disorders actually entering treatment
- Less than 50% of clients successfully completing treatment
- Lack of research-informed clinical practice
- Loosely structured attempts by service providers to connect clients to non-treatment recovery supports
- Short service duration
- Few clients receiving post-treatment follow up and/or support
- Over half of people returning to substance use within a year of discharge from treatment
- Over half of people starting treatment with prior treatment experience; 19% with 5 or more prior treatment episodes
- Low appeal to people with lower levels of problem severity due to focus on a primary goal of abstinence

# Acute-Care Model

Service Characteristics (White, 2008; White & McLellan, 2008)

- Decision-making dominated by the professional
- Short-term service relationship
- Expectation of complete resolution of the problem post-treatment
- Services delivered in a uniform series often consisting of
  - Screening
  - Admission
  - Initial assessment
  - Treatment
  - Discharge
  - Termination of service relationship
- Re-entry into treatment is interpreted as a failure on the part of the individual rather than inadequate treatment design

# ROSC: 12 Guiding Principles of Recovery

| (Sheedy & Whitter, 2013) |
| --- |
| 1. There are many pathways to recovery. |
| 2. Recovery is self-directed and empowering. |
| 3. Recovery involves a personal recognition of the need for change and transformation |
| 4. Recovery is holistic. |
| 5. Recovery has cultural dimensions. |
| 6. Recovery exists on a continuum of improved health and wellness. |
| 7. Recovery emerges from hope and gratitude. |
| 8. Recovery involves a process of healing and self-redefinition. |
| 9. Recovery involves addressing discrimination and transcending shame and stigma. |
| 10. Recovery is supported by peers and allies. |
| 11. Recovery involves (re)joining and (re)building a life in the community. |
| 12. Recovery is a reality. |

# 17 Elements of ROSC Services

| (Sheedy & Whitter, 2013) | |
|---|---|
| 1. Person-centered | 9. Responsiveness to personal belief systems |
| 2. Inclusive of family and other ally involvement. | 10. Commitment to peer recovery support services |
| 3. Individualized and comprehensive services across the lifespan | 11. Inclusion of voices and experiences of recovering individuals and families |
| 4. Systems anchored in the community | 12. Integrated services |
| 5. Continuity of care | 13. System-wide education and training |
| 6. Partnership-consultant relationships | 14. Ongoing monitoring and outreach |
| 7. Strength-based | 15. Outcomes driven |
| 8. Culturally responsive | 16. Research-based<br>17. Adequately and flexibly financed |

# Research Questions

1) Do the beliefs about treatment held by clinicians, probation officers working with offenders, and administrators overseeing these services align more with aspects of the acute-care model or the recovery-oriented systems of care model?

- Where do these beliefs come from and to what degree is this a function of the current system of care in place?

**2) What barriers in the current system of care at community mental health centers and corrections services would have to be removed in order for these professionals to act in line with a recovery-oriented system of care?**

**3) What facilitators exist in the current system of care at community mental health centers and corrections services that would allow alignment with a recovery-oriented system of care?**

# Methods

# Procedures

Semi-structured individual interviews

Purposive sampling methods

- Invited (via email, phone call, or in-person) 12 substance use treatment professionals and 14 probation professionals to participate in this study.
- The sole inclusion criteria for the therapist, probation officer, and administrator sample was that they provide services (i.e., treatment and supervision) directly addressing substance abuse and dependence in the community.
- Treatment professionals
  - Substance use therapists working with clients in treatment (self-referred or court-ordered)
  - Treatment administrators supervising therapists and overseeing services at their agency
- Probation professionals
  - Officers supervising offenders by court order
  - Administrators supervising officers and overseeing agency services
  - An addiction-based case manager connecting clients to community resources

# Recruitment

Therapists providing substance use treatment and their administrators were recruited from a county-wide community mental health organization

Probation officers and their administrators were recruited from the same counties, and, from distinct supervising agencies including Diversion, Court Services, Community Corrections, and Parole.

Sample gathered in the Midwest throughout an urban area (population over 50,000) and nearby rural communities.

Sample totals:

- 9 substance use treatment professionals (7 substance use therapists, and 2 substance use treatment supervisors)
- 9 probation professionals (5 probation officers, 3 probation administrators, 1 addiction-based case manager)

# Participants

## TREATMENT PROFESSIONALS

Average age: 37

Average years in profession: 6

Average years in role: 3

Males: 3

Females: 6

Therapists: 7

Administrators: 2

## PROBATION PROFESSIONALS

Average age: 43

Average years in profession: 20

Average years in role: 12

Males: 4

Females: 5

Probation officers: 3

Diversion Officer: 1

Parole Officer: 1

Case Manager: 1

Administrators: 3

# Data Collection

All participants interviewed individually by primary investigator

- Approximate interview time: one hour
- Range: 35 to 77 minutes

Interview guide used with prompts to help generate content about the beliefs held by the professionals and their organizations regarding substance use dependence and recovery, the structure around the services provided, and the different facilitators and barriers to their ideal work.

All interviews were audio recorded and transcribed verbatim

- Each transcript reviewed 3 times
- The audio files and digital transcript files were encrypted and stored securely to maintain participant confidentiality.
- As much as possible the audio files were de-identified, however, some participants used their own names or co-workers' names when responding to the questions.
- No client names were used in the audio recordings.
- All transcripts were de-identified to increase protections of confidentiality

# Analysis

Deductive approach

- Directed content analysis (Hsieh & Shannon, 2005)
- Steps of analysis
  - Identified all text that seemed to describe either facilitators or barriers to implementing recovery-oriented practices
  - Sorted the identified text into the codes representing either individual or system level factors

After initial codes were determined (facilitator or barrier), another round of deductive coding was completed to identify the sub-categories of the content identified (individual or system level)

- After initial coding, research team members and I met to evaluate mismatching codes and determine an appropriate consensus
- A final round of coding was performed to identify sub categories of system-level barriers and facilitators as well as individual level barriers and facilitators

# Analysis & Trustworthiness

Each transcript was analyzed by two coders

- As primary investigator, I coded every interview and partnered with my research team members who were assigned to code the interviews they were responsible for transcribing.

Accountability for Biases

- Open discussion of reactions to interviews and other perspectives to consider

Researcher reflexivity

- Self-reflection
- Research team reflections

Member checking

- Key informants selected to review summary of results and comment on fit with their lived experience

# Results

| **ROSC Principles:** | **Treatment %** | **Probation %** | **Total #** | **% of ROSC** |
|---|---|---|---|---|
| *Many pathways* | *79* | *21* | *28* | *2* |
| ***Self-directed/Empowering*** | ***62*** | ***38*** | ***140*** | ***10*** |
| *Recognition of need for change* | *52.5* | *47.5* | *40* | *3* |
| ***Holistic*** | ***47*** | ***53*** | ***116*** | ***8*** |
| *Cultural dimensions* | *80* | *20* | *5* | *.4* |
| *Continuum of improved health* | *50* | *50* | *82* | *6* |
| *Emerges from hope* | *40* | *60* | *15* | *1* |
| *Healing and Self-redefinition* | *65* | *35* | *20* | *1.4* |
| *Transcending shame and stigma* | *95* | *5* | *19* | *1.4* |
| *Supported by peers and allies* | *75* | *25* | *12* | *.9* |
| *Re-joining life in community* | *22* | *78* | *27* | *2* |
| *Recovery is a reality* | *33* | *67* | *3* | *.2* |
| ***Totals for ROSC Principles**:* | ***56*** | ***44*** | ***507*** | ***37*** |

# Most Mentioned ROSC **Principles**

| **ROSC Principles:** ROSC | Treatment % | Probation % | Total # | % of |
|---|---|---|---|---|
| *Self-directed/Empowering* | *62* | *38* | *140* | *10* |
| *Holistic* | *47* | *53* | *116* | *8* |

# Exemplar Quotes: ROSC Principles

***Self-directed/Empowering***

- Treatment Professional: *"…….. I feel like that's one of my main roles is just helping them to consider their life, to look at it to reflect it, to mirror it to whatever it is that they can consider what's going on in their life and decide if that they want to keep doing that or if they want to do something different."*

- Probation Professional: *"I always tell them, you guys are driving the bus. You're the bus driver. You get to decide where you go. You get to decide if you turn right, you get to decide if you turn left, you're stopping, who you're letting on, who you're letting off, but along the way you might need some help, such as you might need some directions."*

***Holistic***

- Treatment Professional: *"One of the things that I would consider necessary to have for them to complete successfully, is to make sure that they have that system of care in place. In that, when they enter treatment here, we're not just looking at one aspect of them, that we're looking at all aspects, and all the systems that they have into play. You know, not only the addictions piece but the mental health piece, the physical health piece."*

| ROSC Elements: | Treatment % | Probation% | Total # | % of ROSC |
|---|---|---|---|---|
| ***Person-centered*** | ***57*** | ***43*** | ***196*** | **14** |
| *Inclusive of family and allies* | *82* | *18* | *49* | *4* |
| ***Individualized/comprehensive*** | ***53*** | ***47*** | ***118*** | ***9*** |
| *Anchored in the community* | *39* | *61* | *67* | *5* |
| *Continuity of care* | *49* | *51* | *67* | *5* |
| *Partnership-consultant relationship* | *47* | *53* | *83* | *6* |
| *Strength based* | *57* | *43* | *42* | *3* |
| *Culturally responsive* | *100* | *0* | *3* | *.2* |
| *Responsive to personal beliefs* | *56* | *44* | *9* | *.7* |
| *Commitment to peer recovery* | *62* | *38* | *13* | *.9* |
| *Inclusive of voices of recovery* | *67* | *33* | *3* | *.2* |
| ***Integrated services*** | ***40*** | ***60*** | ***103*** | ***7*** |
| *Education and training* | *52* | *48* | *29* | *2* |
| *Ongoing monitoring and outreach* | *35* | *65* | *34* | *2.5* |
| *Outcomes-driven* | *0* | *100* | *6* | *.4* |
| *Research based* | *23* | *77* | *26* | *2* |
| *Adequately/flexibly financed* | *35* | *65* | *26* | *2* |
| ***Totals for ROSC Elements:*** | ***50*** | ***50*** | ***874*** | ***63*** |

# Most Mentioned ROSC **Elements**

| ROSC Elements: | Treatment % | Probation% | Total # | % of ROSC |
|---|---|---|---|---|
| *Person-centered* | *57* | *43* | *196* | 14 |
| *Individualized/comprehensive* | *53* | *47* | *118* | *9* |
| *Integrated services* | *40* | *60* | *103* | *7* |

# Exemplar Quotes: ROSC Elements

***Person-centered***

- Treatment Professional: *"I want our focus to be more on where is the client at, and do they really need this group, or do they not need this group. And really what do they need versus what do we think they need."*

***Individualized/comprehensive***

- Treatment Professional: **"***When clients circle back, I think we just we consider that's just part of it. That is part of addiction. That's a part of mental health, is that it's probably not gonna be cured, or go away, or however you wanna say the first time. It's a chronic disease that's always going to be a part of them. So we just welcome them back and pick up where they left off. We ask them, you know, do you want to see the therapist you used to see? So, if that therapist is here, then we try to make that accommodation if they want it."*

***Integrated services***

- Probation Professional: **"***Some of the people who are in intensive outpatient, well we go to wraparound monthly, but they're having contact with those treatment providers on a regular basis, which is something that has evolved over time too, we didn't, use to know whether people were going to treatment or not, and now we have a combined position with the community mental health center, a shared position."*

| **Acute Care Subthemes:** | **Treatment %** | **Probation %** | **Total #** | **% of Acute** |
|---|---|---|---|---|
| *Prompted by crisis* | *17* | *83* | *6* | *2* |
| *Brief treatment/intervention* | *81* | *19* | *16* | *6* |
| *Purpose of stabilization* | *40* | *60* | *20* | *7* |
| *Singular focus on sobriety* | *27* | *73* | *15* | *5* |
| ***Professional-dominated decisions*** | ***21*** | ***79*** | ***76*** | ***27*** |
| *Short-term service relationship* | *83* | *17* | *6* | *2* |
| *Expectation of problem resolution* | *29* | *71* | *17* | *6* |
| ***Uniform delivery of services*** | ***24*** | ***76*** | ***70*** | ***25*** |
| *Re-entry interpreted as failure* | *18* | *82* | *17* | *6* |
| *Lack of research-informed care* | *39* | *61* | *18* | *6* |
| *Few connections to non-treatment* | *25* | *75* | *8* | *3* |
| *Lacking follow up post-treatment* | *33* | *67* | *12* | *4* |

# Most Mentioned Acute-Care Subthemes

| Acute Care Subthemes: | Treatment % | Probation % | Total # | % of Acute |
|---|---|---|---|---|
| *Professional-dominated decisions* | *21* | *79* | *76* | *27* |
| *Uniform delivery of services* | *24* | *76* | *70* | *25* |

# Exemplar Quotes: Acute-Care Subthemes

***Professional-dominated decisions***

- Treatment Professional: *"And when going back to client centered, yes we want to do what the client wants, but we also have to make sure they're following all their court orders."*

- Probation Professional: *"You like to smoke weed because you're too lazy to deal with your problems. That can be dealt with in [treatment] just fine. Ha, what? They go. That's your reality dude. It's hard work, you have to deal with it."*

***Uniform delivery of services***

- Treatment Professional: *"I think, there's some treatment providers that really try to put clients in boxes like, ok, this is our level one program and you're going to go through this group exactly like this, and you're going through this group and then this group, and then you'll be done."*

- Probation Professional: *"So then we have the drug case that is a non-senate bill case. That's exact- That works the exact same way. I meet with them. We determine they have and have had a drug problem, and I make a recommendation in the PSI (pre-sentencing investigation) at sentencing, then, they have to go get it and pay for it and this and that."*

# Results: Research Question 2

What **barriers** in the current system of care at community mental health centers and corrections services would have to be removed in order for these professionals to act in line with a recovery-oriented system of care?

*Barriers*

| Individual-level | Total Count |
|---|---|
| Treatment Sample: 18% | 36 |
| Probation Sample: 18.3% | 42 |
| **System-level** | **Total Count** |
| Treatment Sample: 82% | 164 |
| Probation Sample: 81.6% | 187 |

# Exemplar Quote: **Individual** Barrier

Individual barrier for probation professional when acting in more of an acute-care model approach of decision making being dominated by the professional:

*“Cause I walk the walk with them sometimes when I'm doing direct client services and I get super frustrated I'm like "ugh, he just needs to go to jail!" But because, that's how we were all trained initially, and it's so so, it's easier to lock somebody up than get them to change their behavior, to do the hard work, y'know.”*

# Exemplar Quote: **System** Level Barrier

Probation professional describes the limitations to probation work that occur at the system-level:

*"There's often gaps between, let's say they have to go to prison and do 120 days. And maybe they have their medication but when they're incarcerated they miss their appointment and they only give you enough for 30 days when you're discharged, just as an example. And so, y'know there's gaps in getting them in for their medication recheck […] So there's gaps from institution to the community and back…"*

# RQ 2 Results: Individual Level Barriers

*High Workplace Demands*

5/9 Treatment Professionals

8/9 Probation Professionals

*Uncertainty/Early Development*

6/9 Treatment Professionals

4/9 Probation Professionals

*Human factors*

1/9 Treatment Professionals

5/9 Therapy Professionals

# Exemplar Quotes: Individual Level Barrier Subtheme

***High Workplace Demands***

- Treatment Professional: *"Client load is huge. ...and the direct service hours is, for me overwhelming."*

- Probation Professional: *"You get phone calls from victims wanting to know where their money for restitution is, you get criticized by the judge for not doing enough for the offender, what are you doing to make this person change, when, here this is what we've done. You get blamed by law enforcement for being too soft on the offenders, you get called "hug a thug" and all those different types of things, and that can have a really negative impact on you and your job satisfaction. Once you hit that burnout stage, it's very challenging to come out of."*

# Exemplar Quotes: Individual Level Barrier Subtheme

***Uncertainty/Early Development***

Treatment professional describing the reactions novice substance use therapists often have to relapse before understanding the nature of addiction:

*"Especially when you first start as an alcohol and drug therapist you're wanting them- your goal is for them to stop using drugs. I mean it's what we're here to do. And so, uh, yeah I would say that might be an over focus where relapse can be really frustrating for a therapist too. Um, or you know not making progress on their goals or they didn't do their homework or whatever it is."*

A probation professional offers a view into a shift he made from a more acute-care stance of dominating the change process to a more recovery-oriented stance of letting the client direct the care:

*"So, that probably took, y'know a few months to kinda start to piece together and just maybe just calm down about my position enough to want to (laughing) realize like okay here, you don't have to save the world, like let's slow down and just kinda allow the clients to guide it a little bit better, um. So now it's more of a partnership I think…"*

# Exemplar Quotes: Individual Level Barrier Subtheme

***Human Factors***

Treatment Professional: "*…and how sometimes I would have an emotional response to something and um that might affect how I treat that person, um, when they're not working towards what I would like to see them work towards. Um but you know, cause you view it as like it's the right thing to do, it's what the book says, it's that, but the client just isn't there yet*"

Probation Professional: "*But I think human nature too, to some extent pulls us back into, it's just, change work is hard. Especially, I mean I have a criminology degree. […]. My goal, I wanted to be an FBI agent. I wanted to lock people up, like that's what I wanted to do and I would say a majority of my staff that have a criminal justice degree went into it from a law enforcement perspective. We went into it because we maybe didn't want to wear those ugly blue uniforms, but we still have some control issues.*"

# RQ 2 Results: System Level Barriers

*Inadequate Funding*

9/9 Treatment Professionals

9/9 Probation Professionals

*Mismatched goals/priorities*

4/9 Treatment Professionals

8/9 Probation Professionals

*Untimely/Disjointed Services*

4/9 Treatment Professionals

7/9 Probation Professionals

*Red Tape*

4/9 Treatment Professionals

5/9 Probation Professionals

*Poor Recovery Environment*

4/9 Treatment Professionals

4/9 Probation Professionals

*Lack of Education & Training*

4/9 Treatment Professionals

1/9 Probation Professionals

# Exemplar Quotes: System Level Barrier Subtheme

***Inadequate Funding***

- Treatment Professional: *"I wish we could do, make more decisions based off of the clinical piece and not just whether we can get paid for it. Like in one of our smaller offices now, you know trying to, maybe you've got these clients that have a type of insurance that we have no therapist that's credentialed with that insurance and so we can either continue to provide these services, basically, and write off the charges, which isn't good, or you know, you have to tell them that we can't see them and they're going to have to travel 'cause there's nobody else there. That's a hard thing to do and it's...I don't like putting clients or therapists in that position."*

- Probation Professional: *"We don't have anybody statewide that wants to manage a grant, so we do have an officer that's put in for a grant locally […] that hopefully we get […] so, it'd be nice to be able to remove some barriers."*

# Exemplar Quotes: System Level Barrier Subtheme

***Mismatched goals/priorities***

- Probation Professional: "*I do wish that we had more support and understanding of the policy and lawmakers as to the decisions that they make and how they impact us at the local level. For example, the huge shift on the juvenile justice side, I agree with the philosophy behind the shift, but I do not agree with the strategic plan that they've put in place and the pressure that that puts upon us in order to get it all done. And for it to be effective and impactful for the juvenile population in [state name]. I think that we have a lot of folks in those decision-making roles that just don't have enough knowledge and experience in understanding the negative impact of the decisions that they're making.*"

# Exemplar Quotes: System Level Barrier Subtheme

***Untimely/Disjointed Services***

- Treatment Professional: "*When a client needs inpatient, they could, if they are state grant funded, […], however you want to say, they could be waiting a month, a month and a half, two months for a bed. And so I think that's a big challenge for them in their treatment they need inpatient treatment now, not two months from now, cause who knows what could happen in two months? So I think that's a huge challenge.*"

- Probation Professional: *"There's often gaps between, let's say they have to go to prison and do 120 days. And maybe they have their medication but when they're incarcerated they miss their appointment and they only give you enough for 30 days when you're discharged, just as an example. And so, y'know there's gaps in getting them in for their medication recheck."*

# Exemplar Quotes: System Level Barrier Subtheme

***Red Tape***

- Treatment Professional: *"We wouldn't have, you wouldn't have to go through the whole admissions. I think that's a barrier to treatment. So, you leave treatment because you're doing well, and then to get back into treatment, you have to go through this huge kind of clunky admissions process of the intake, the [substance use services intake], the admissions paperwork."*

- Probation Professional: *"However, the law, since she plead to that one over there (another town) before she was sentenced on this one, that is now a third (offense) for my case as well. So that eliminates her eligibility to [funded treatment], and it changes the presumption on my- because the way the law is, anything that happens before you get sentenced impacts your case."*

# Exemplar Quotes: System Level Barrier Subtheme

***Poor Recovery Environment***

- Treatment Professional: *"Again I think that there's added challenges to that when you get into some of the more rural communities, because you're bringing in the fact that these are small towns. They've burned their bridges with the two employers in town, where else do you go? If their family is from that town and has lived in that town, you know for the past hundred and fifty years, trying to say 'well maybe if you can't get out of these places and situations, it's time to look to relocate. I mean that's, it's like a huge shift for them as far as 'ok what's more important: being here with my family and probably go back to using, or should I move away and stay sober?' well I think that's, unfortunately, yeah, more in smaller towns, it's just a lot of, I mean, 'my dad used, I used, my wife uses, my kids [laughter] use' type mentality."*

# Exemplar Quotes: System Level Barrier Subtheme

***Lack of Education & Training***

- Treatment Professional: A therapist, describing a misunderstanding of recovery from the client's support group said, *"And a lot of times they're like why aren't they better? Why are they still you know they're still using."*

- Probation Professional: "*There needs to be education that goes on at the state level, […] with legislators in that, even though you're not cutting my budget, you're not giving me any more money for increased insurance costs, […]. So even though maybe I've had the same amount for the last three years, well I'm really $50,000 in the hole because of cost of living increases, things like that and so eventually I have to reduce staff, hours or positions."*

# Results: Research Question 3

What **facilitators** exist in the current system of care at community mental health centers and corrections services that would allow alignment with a recovery-oriented system of care?

*Facilitators*

| Individual-level | Total Count |
|---|---|
| Treatment Sample: 50% | 102 |
| Probation Sample: 41.5% | 122 |
| **System-level** | **Total Count** |
| Treatment Sample: 50% | 102 |
| Probation Sample: 58.5% | 172 |

# Exemplar Quote: **Individual** Facilitator

Probation Professional describes his style in working with clients and reasoning for doing so:

*"I haven't been doing this for 16 years just to receive a paycheck, it's to truly help individuals. And that's one thing I really strive to do when I meet with my clients is try to show 'em how loyal I am to 'em, how honest I will be to them, you know."*

# Exemplar Quote: **System** Facilitator

Treatment Professional offers her take on how other professionals have benefited her work:

*"Sometimes we do get POs that are very very supportive and they are already educated and that makes it a lot easier for us because we are both on the same page, we're both communicating all the time."*

# RQ 3 Results: Individual Level Facilitators

*Autonomy*

5/9 Treatment Professionals

6/9 Probation Professionals

*Desire for successful outcomes*

4/9 Treatment Professionals

6/9 Probation Professionals

*Job Experience*

4/9 Treatment Professionals

3/9 Probation Professionals

# Exemplar Quotes: Individual Level Facilitator Subtheme

***Autonomy***

- Treatment Professional: *"I feel like I've kinda had some opportunity just to start a group here or do you know what I wanted to do in the groups and I was given some freedom to explore that and figure out what worked for the clients."*

- Probation Professional: *"And then sort of a case management component too where I can, y'know the clients that need the extra help to actually follow through with getting some of those resources I can, I have the flexibility to leave the office to actually go help them meet with people at the Bread Basket or whatever it is to kind of meet some of those needs too."*

# Exemplar Quotes: Individual Level Facilitator Subtheme

***Desire for successful outcomes***

Treatment Professional: *"I don't micromanage cause I don't have to micromanage. I think that this staff--they could run this program themselves without me, because they're so motivated and they care about this program that I don't think that; I don't have to do a lot. My job is pretty easy."*

Probation Professional: *"The approach that they have...that's kind of a hard question, but I would just say, uh, I think they, of course, they're in the business of trying to help clients, and they want that to be their primary focus and mission in what they want to accomplish."*

# Exemplar Quotes: Individual Level Facilitator Subtheme

***Job Experience***

Treatment Professional: *"I think, in a lot of ways just kind of exposure and experience. You know, when I first came in of course you're coming out of grad school and you have all these great templates for treatment and you're like okay I'm gonna use this therapeutic mentality and I'm going to use this application, I'm gonna use this method, and you learn pretty quickly, I feel like especially in the A&D (alcohol and drug) field is these textbook applications, they're not going to apply and work the same way with a lot of our clients."*

Probation Professional: *"My staff are pretty good at articulating, um... What they see as happening in the client's situation, um. They're assertive, they just have a lot of years experience."*

# RQ 3 Results: System Level Facilitators

*Professional Collaboration*

9/9 Treatment Professionals

9/9 Probation Professionals

*Supportive Workplace Environment*

3/9 Treatment Professionals

6/9 Probation Professionals

*Creative/Grant Funding*

3/9 Treatment Professionals

5/9 Probation Professionals

# Exemplar Quotes: System Level Facilitator Subtheme

***Professional Collaboration***

- Treatment Professional: *"Honestly I think it starts at the top, kind of, with...having good communication between the program directors. ..and saying 'what can we do?' 'can we do?' and then taking that back to staff and saying 'you know we're [inaudible] gonna work on this' and you know, so I think it kind of starts at the top, but I think most of the work is done with, kind of the therapists and the […] corrections officers. I don't wanna [laughter] I don't wanna be like to downplay that at all, but I think it starts with having good relationships at the top and a willingness to work together."*

- Probation Professional: *"And that has super enhanced our... communication and relationships with not just [community mental health center] but I think... staff have seen the benefits of that close relationship with the provider, and so it's even enhanced our work with [another treatment agency] or some of the private providers in town, just knowing that "we all have to be on the same page". And working towards the same goals, using the same language, y'know?"*

# Exemplar Quotes: System Level Facilitator Subtheme

***Supportive Workplace Environment***

Probation Professional: "*We got a wonderful team here, so, we all work and collaborate super well and, you know, we're all loyal to each other, and that goes a long ways. I'm quite honestly not trying to brag, I do believe we are one of the best agencies in the state […] when it comes to supervision and that's part of it is because we work so well together and we're loyal to each other and we got each other's back.*"

# Exemplar Quotes: System Level Facilitator Subtheme

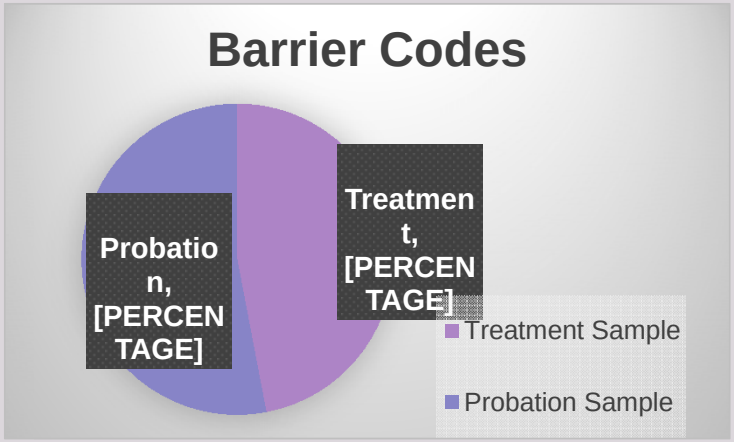
***Creative/Grant Funding***

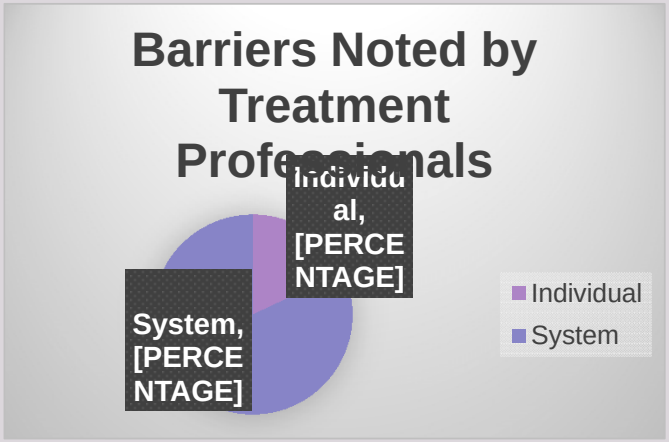
Probation Professional: *"And that has dwindled over time and it's probably, I've always [had], around $30,000, and it's probably down to about $15,000-ish now, but we have sought outside grants, we have a city alcohol grant, we have [another] grant, and then a behavioral health grant from the [agency]. So I've been able to shift the direct client services to those grants. So we're still spending the same amount of money."*

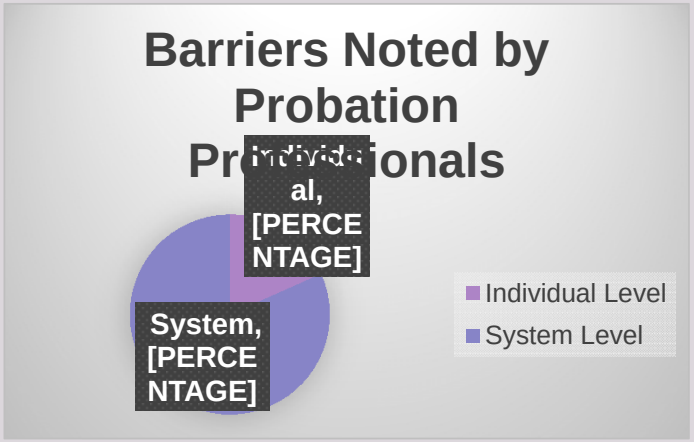
Probation Professional: *"Um, so that's been awesome. Both sides help each other with grants and things like that, so sharing ideas about "hey what if we, what if you applied for this grant funding and we applied for this grant funding, that way we're sort of bridging the gap between these services for clients," has been really neat."*

# Discussion

# Discussion: Research Question 2

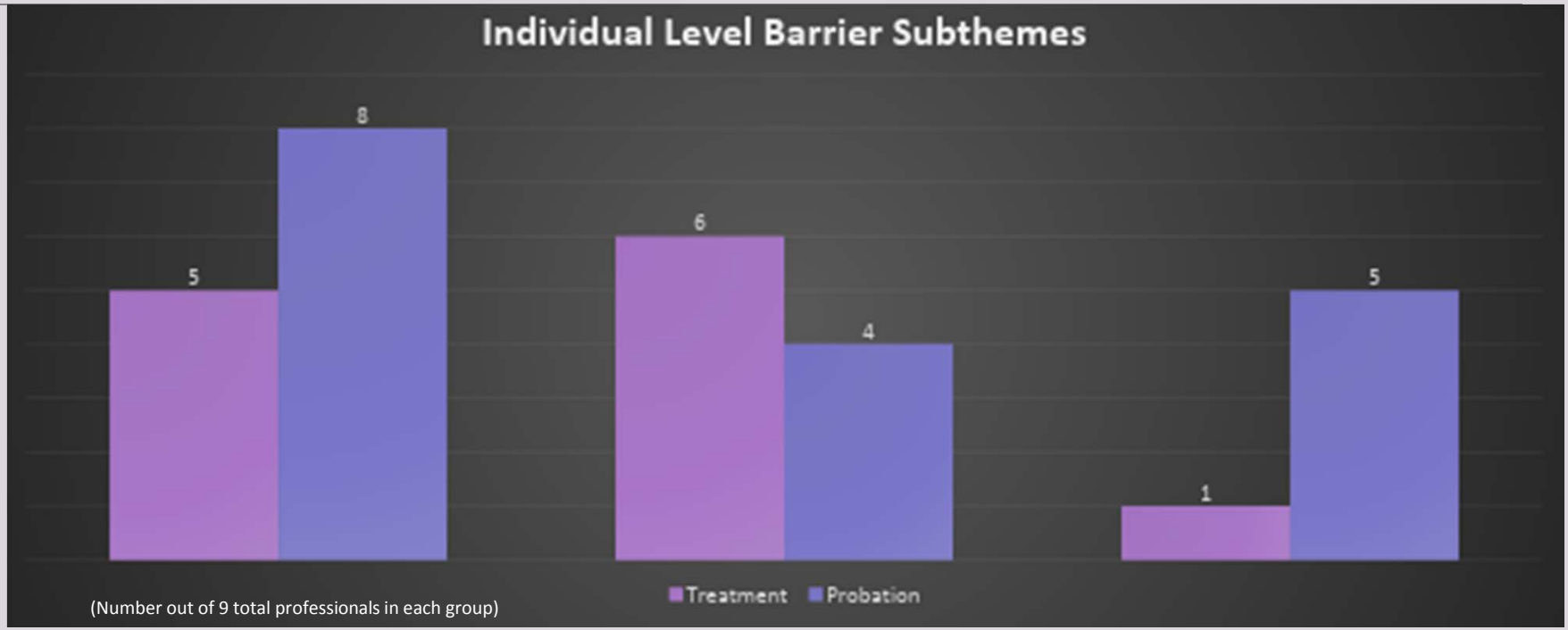



With a large source of barriers perceived as coming from the **system level** for both treatment and probation professionals, it seems this is an area of great need for attention in the transition toward a ROSC model, whereas individual-level barriers are much less.

# RQ 2 Discussion: **Individual** Level Barriers



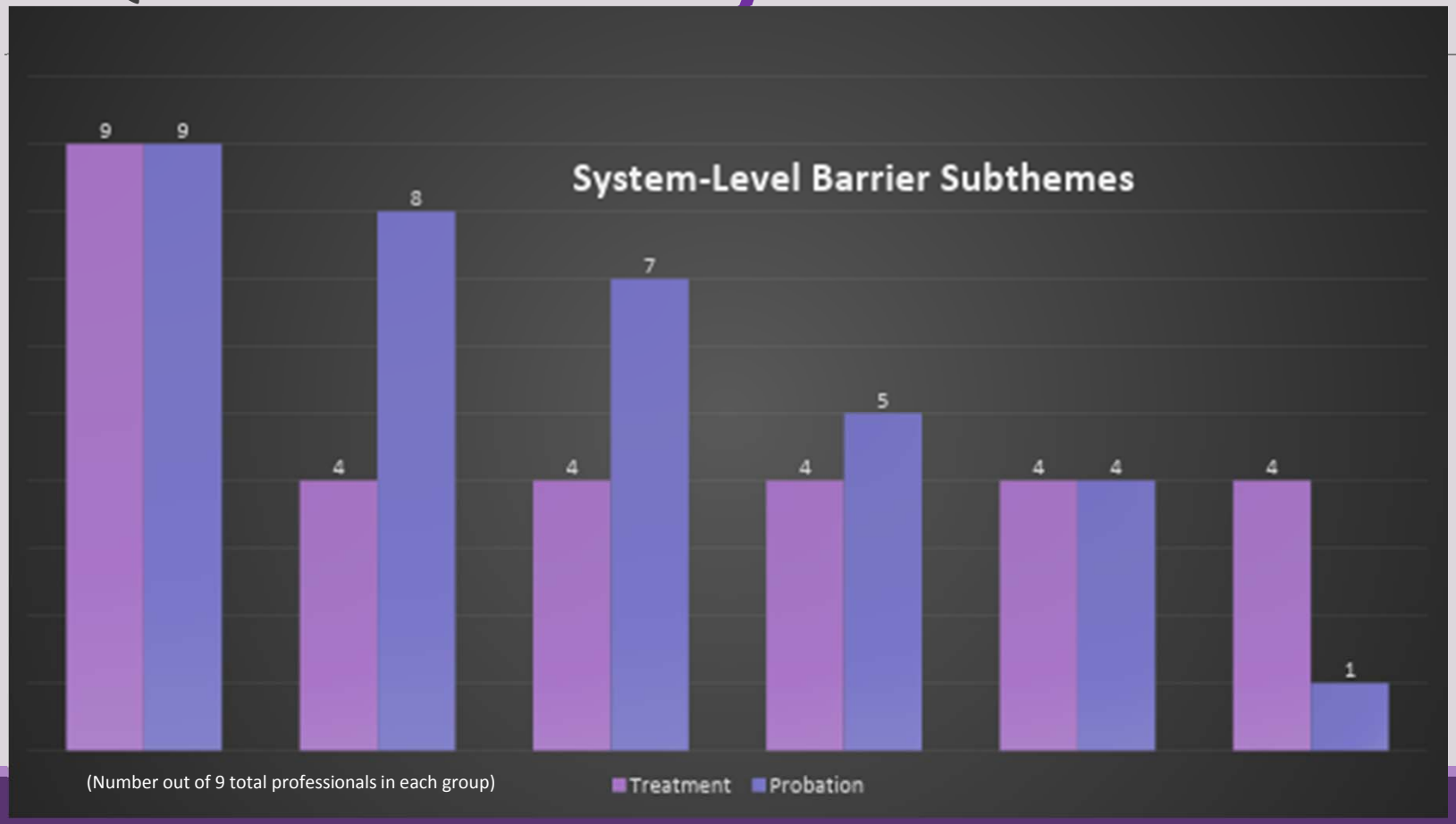
# RQ 2 Discussion: **Individual** Level Barriers Contd.

**Individual barriers** did not emerge near as much as the system level barriers. This is likely related to the stronger alignment participants had with the ROSC model on an individual-level, making individual barriers to implementing a ROSC model less frequent.

***High workplace demands*** (treatment: 5/9; probation: 8/9)

- Fits with the literature as this is a known challenge for service providers found in prior research both generally (Bakker & Demerouti, 2007), and specifically for those in the healthcare system implementing ROSC (Kirk, 2010).
- Dominant theme for probation professionals
  - As many probation agencies took on evidenced based practices recently, it seems they have found certain pieces of the paperwork unnecessary or repetitive.
  - With being short on staff, many probation officers noted an inability to do "field work" (meeting with clients outside of the office) since it requires two of them to go at one time.
    - Ultimately limits their ability to be anchored in the community as the ROSC model would suggest.

# RQ 2 Discussion: **System** Level Barriers

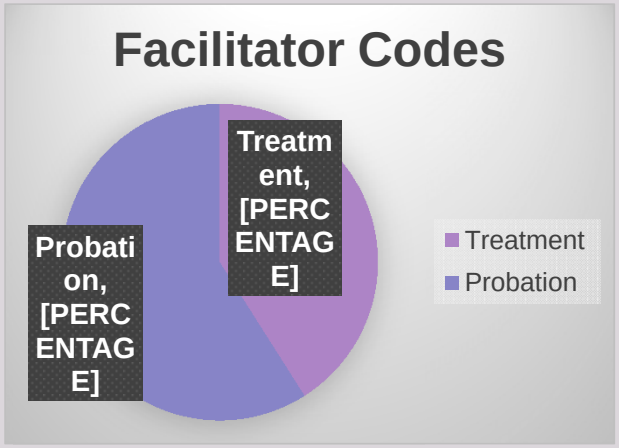


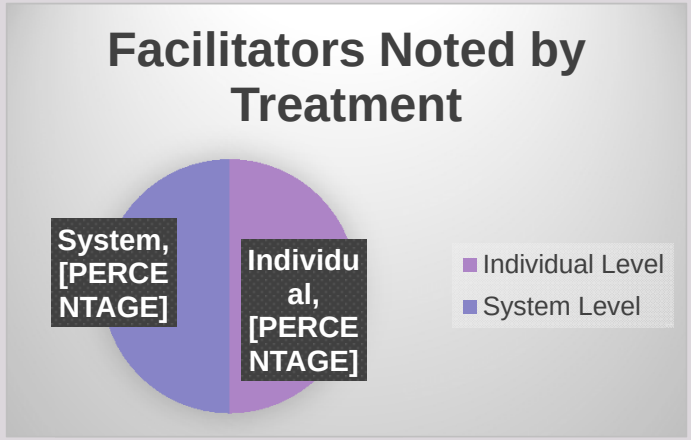
# RQ 2 Discussion: **System** Level Barriers Contd.

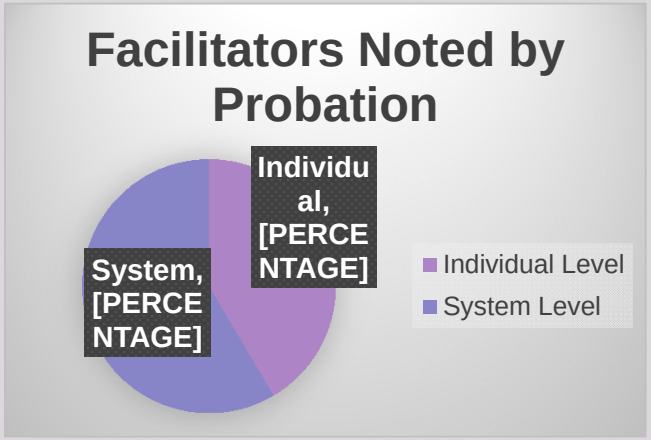
*Inadequate funding* (treatment: 9/9; probation: 9/9)

- Most often first barrier to be mentioned
- It was apparent that these professional systems exist within a greater financial issue at the state level
- Professionals mentioned the cuts made to mental health services, prevention efforts, programming in prisons, inpatient facilities, and services to families
  - Grant funding was often a solution to this problem, and both probation and treatment systems seemed to have access to grant money
- Although funding is not the only missing link to implementing a ROSC model, it is a significant barrier for communities in need of additional services to clients

# Discussion: Research Question 3

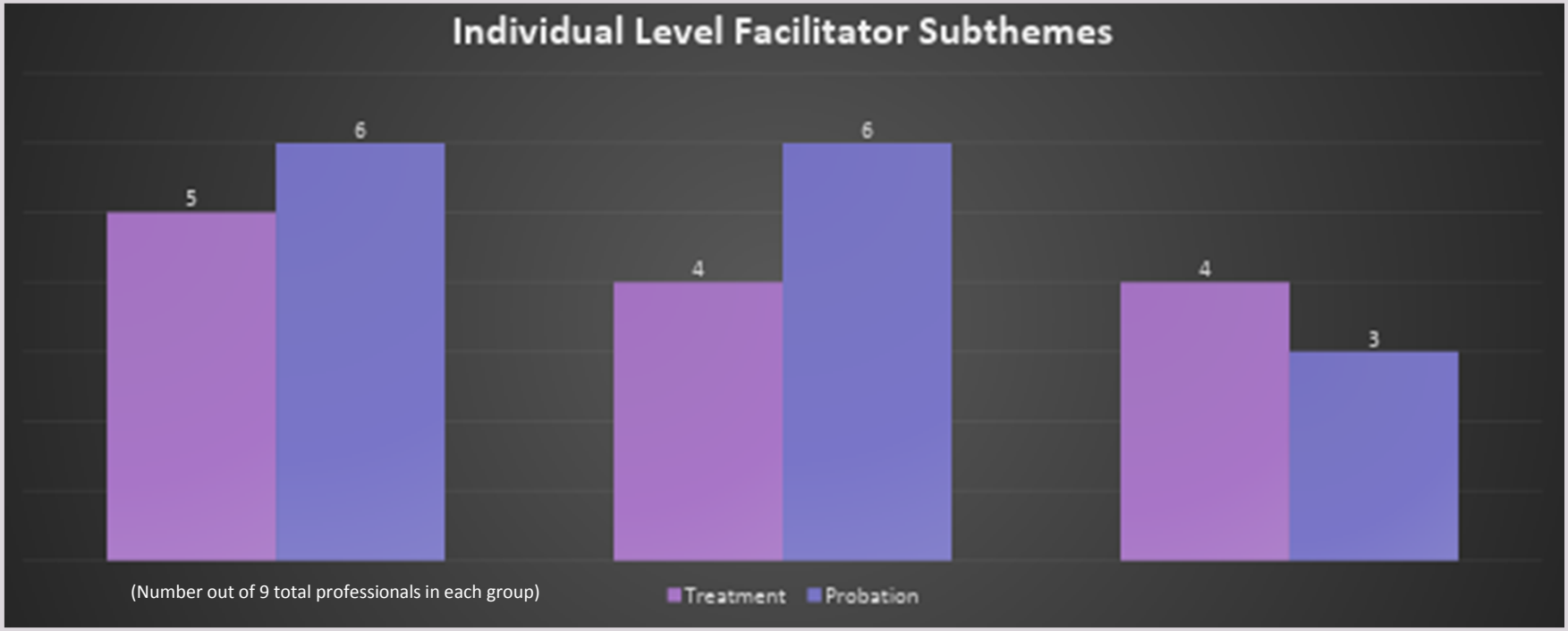



**System-level factors** stand out as essential in facilitating ROSC model practices for the probation professionals.

# RQ 3 Discussion: **Individual** Level Facilitators

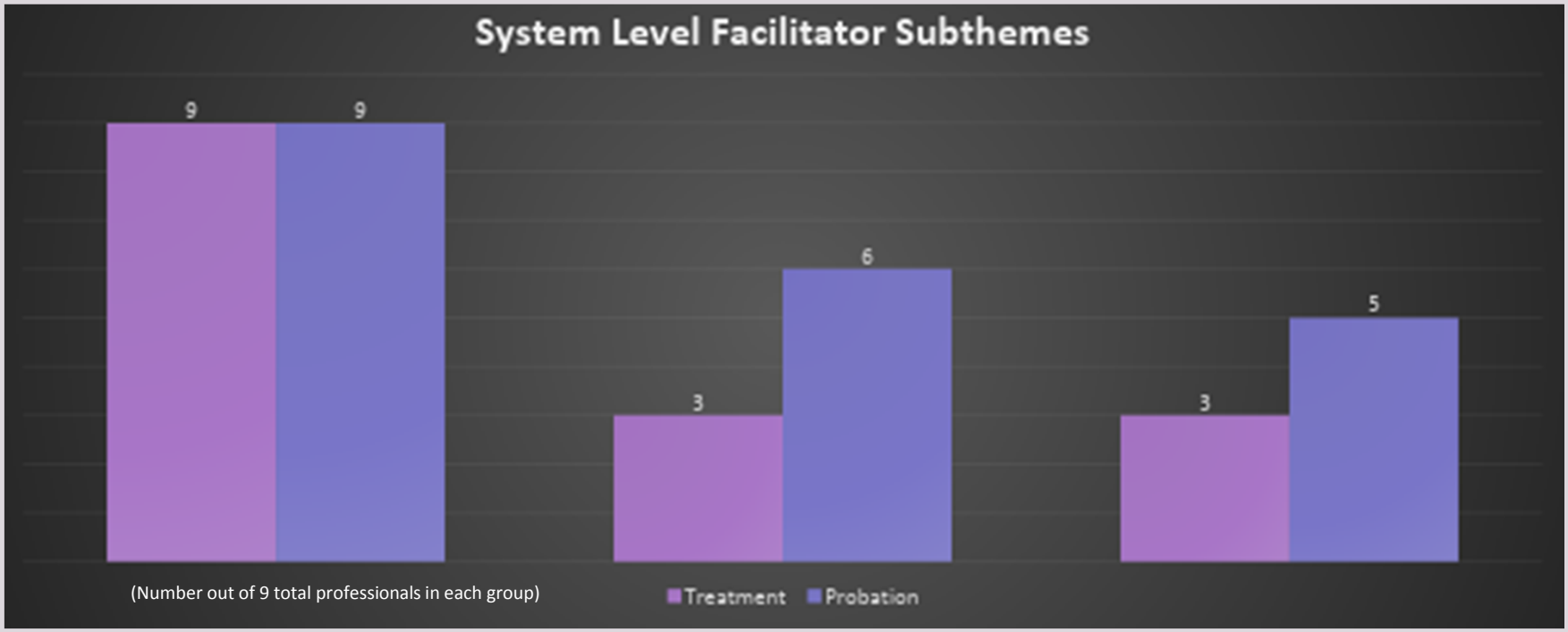


# RQ 3 Discussion: **Individual** Level Facilitators Contd.

***Autonomy*** (treatment: 5/9; probation: 6/9)

- Powerful facilitator at the individual level considering the substantial amount of individual-level ROSC model alignment codes found in this data.
  - Has the potential of being dangerous when used against ROSC model elements, however, with many individual professionals holding ROSC model principles, autonomy is important to have when working under otherwise acute-care saturated systems.
- Professionals described this subtheme as key to feeling supported in the practices they thought were best for the client.
- Probation professionals acknowledged that they have a lot of contact with clients and have a good deal of insight into their situation above and beyond the judge so having some autonomy in how to respond when clients are not in compliance with the court order was helpful for the probation officer to be able to present options.
- Treatment providers talked about their training backgrounds and how it was helpful to have the freedom to provide services in line with their training and beliefs on change (e.g., inviting family members to session).

# RQ 3 Discussion: **System** Level Facilitators



# RQ 3 Discussion: **System** Level Facilitators Contd.

***Professional collaboration*** (treatment: 9/9; probation: 9/9)

- Clear that collaborating with essential supports to the client regardless of service system was a major facilitator of practices in line with the client's benefit.
- Many discussed the importance of gathering information from other sources in order to gain a fuller picture of the client's situation or to learn what strengths the other supports see in the client.
- Collaboration seemed to open doors for learning about resources available and accessing those resources for the client.
- By being in close contact with one another, professionals felt more secure in directions to take with clients, and often clients were described as able to be part of this collaboration process as well during "wraparound" services where everyone meets together in one location. Collaboration is known to be an important practice for improving client retention and care (Fletcher, et al., 2009).

# Strengths

Methodology

- All interviews conducted by primary investigator
- Cross coding practices
- Member checking to build trustworthiness

Population

- A closer look at both treatment and probation systems
- Getting perspective on court mandated services, which are prevalent (White, 2008; SAMHSA, 2015)
- Understanding barriers and facilitators of two systems that are often prompted to collaborate and would be necessary to integrate during transition to a ROSC model

# Limitations

## Methodology

- Being a part of the treatment system and the primary investigator conducting interviews
  - Level of openness
  - Curiosity
  - Expectations

## Lack of Within-System Comparisons

- Cannot speak to differences between professionals or agencies
  - Can't connect findings with demographics such as age, development, training, etc

## Participant Homogeneity

- Some findings likely unique to rural Midwest and cannot be generalized to all community types
- Only the two subsystems were investigated, capturing part of the whole community system

# Implications

Among all systems

- Collaboration is an essential step in building integrated systems toward a ROSC model
  - Individual professionals have the power to engage other systems in the process of caring for the client (e.g., therapist inviting probation officer to treatment planning session with client)
  - Administrators can build resources by engaging other systems in joint funding efforts such as grant writing, sharing positions, and advocating for services and educating at the community-level
  - Administrators from multiple systems can also work together in creating policies that are compatible with one another (e.g., implementing policies that support inpatient facilities, outpatient facilities, medication services, and probation working together to create an aftercare plan for each client exiting services and entering new ones)

Relying on strengths of particular subsystems in creating and maintaining change

- Probation professionals noted substantial system-level influence on practices, which can be a source of strength when implementing system-level change
- Treatment professionals noted autonomy as a strength in their role, which can afford them greater flexibility in making changes in line with the ROSC model

# Implications Contd.

Importance of Accountability

- Both treatment and probation systems will need a structure in place to monitor fidelity to the ROSC model
- To implement the ROSC model, ongoing training and follow up will be necessary to prevent sliding back to default practices as found in examples of other communities implementing ROSC (Boyle et al., 2010)
  - Some form of direct supervision would be needed (e.g., supervisor observing video or audio of sessions/meetings with clients)
  - Each new employee would need a baseline training of expectations and accepted practices
  - Ongoing staff trainings would be necessary to maintain attitudes and values consistent with ROSC

# Discussion: Research Question 1

Promising results

- Of all the coded text for model alignment, 83% aligned with ROSC and 17% with acute-care.

Strong individual-level influence

- Contributed most to the alignment codes for both ROSC (77%) and the acute-care model (52%).
- Communities transitioning to a ROSC model must address change at the individual-level of the professional whether this is for promotion of the model or to intervene and reduce individual-level barriers to implementation.

Unique role of probation systems

- Probation professionals dominated the model codes at the system-level for both acute-care (63%) and ROSC (66%) model alignment in comparison to treatment professionals.

Overall, these findings help clarify the

- essential role of the individual professional in establishing and maintaining the ROSC model
- unique influence the probation system has in driving services

# Future Directions

Comparisons **within service systems** of treatment and probation

- Capturing specific barriers and facilitators at work for the differing agencies or training backgrounds
  - Access to resources
  - Quality of skills training
  - Location within other governing systems

Expanding investigation to other, more diverse communities

- Each community will likely hold unique barriers and facilitators for a transition to the ROSC model

Gather the perspectives of other subsystems beyond treatment and probation

- Medical system
- Insurance companies
- Clients
- Law enforcement
- Judges

# Conclusion

- Recovery from addiction is possible, but without certain supports in place within the community it can be an overwhelming challenge for individuals
- The ROSC model offers a comprehensive solution to meeting the needs of people in recovery
- Treatment and probation professionals express good intentions that are mostly aligned with the ROSC model, but some aspects of the acute-care model linger

*There is **power** at the individual level of service providers and **potential** in the structure of systems to promote and maintain recovery-oriented practices.*

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