

Recovery-Oriented Systems of Care (ROSC): Understanding individual and system-level barriers and facilitators to implementation of ROSC in an addictions treatment community

by

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B.S., Kansas State University, 2011
M.S., Kansas State University, 2014

AN ABSTRACT OF A DISSERTATION

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Abstract

Addiction to mood-altering substances i.e., drugs and alcohol is a public health concern impacting society in many contexts (e.g., employment, financial costs, family welfare, healthcare, and criminal activity). As a result of the substantial personal and societal costs associated with substance abuse, significant federal dollars have been spent on addiction recovery services in an attempt to ameliorate the negative impacts of these disorders. Like many chronic diseases, relapse (40-60%; National Institute on Drug Abuse, 2012) and dropout (23-50%) rates for clients in drug and alcohol outpatient treatment tend to be high (McHugh et al., 2013; Santonja-Gomez et al., 2010; Evans, Li, and Hser 2009; Stark, 1992). Over time, it has become clear that a single course of treatment is simply not enough to meet the needs of a person in recovery from alcohol and/or other drug abuse. The field of addiction treatment and recovery has been dominated by an acute-care model of treatment. A new model, recovery-oriented systems of care (ROSC), defined as “networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders” (Sheedy & Whitter, 2013, p. 227), has been endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT). As communities begin to implement ROSC it is imperative to understand the barriers to transitioning out of the traditional, acute-care model. Findings from in-depth qualitative interviews revealed that both treatment and probation professionals described more alignment with the ROSC model than the acute-care model. For treatment professionals, this alignment was stronger at an individual level and for probation professionals it was stronger at the system level. For both professional groups, the system-level barriers to moving toward a ROSC model were much greater than any individual-level barriers. Facilitators

were found evenly split for the most part between individual and system level codes. For communities making movement toward the ROSC model, the systems of treatment and probation have great potential at the individual level for ROSC alignment and have available facilitators for overcoming system-level barriers in place. Although the acute-care model served a purpose at one time, it is now time for the ROSC model to be implemented as a comprehensive response to addiction and needs in recovery.

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Chapter 1 - Introduction

Addiction to mood-altering substances i.e., drugs and alcohol is a public health concern impacting society in many contexts (e.g., employment, financial costs, family welfare, healthcare, and criminal activity). In 2007 the total estimated economic cost of drug abuse in the United States was \$193 billion (National Drug Intelligence Center, 2011) with criminal justice costs (\$61 billion), healthcare costs (\$11 billion), and lost productivity in the workforce (\$120 billion) contributing to this staggering total (National Drug Intelligence Center, 2011). Substance abuse treatment is known to reduce these costs of addiction (Miller & Flaherty 2000). For example, one Fortune 100 company found that their annual medical costs for employees with addiction dropped from \$2,068 per year to \$165 per year after the employees received treatment, not including treatment costs. The total savings of this company on healthcare was \$500 per employee, as well as the indirect savings of increased productivity and decreased employee absenteeism (Miller & Flaherty 2000).

As a result of the substantial personal and societal costs associated with substance abuse, significant federal dollars have been spent on addiction recovery services in an attempt to ameliorate the negative impacts of these disorders. Like many chronic diseases, relapse (40-60%; National Institute on Drug Abuse, 2012) and dropout (23-50%) rates for clients in drug and alcohol outpatient treatment tend to be high (McHugh et al., 2013; Santonja-Gomez et al., 2010; Evans, Li, and Hser 2009; Stark, 1992). The rate of clients re-entering substance use treatment is also high with one study finding that clients were admitted to treatment nearly twice on average in a three-year period (Callaghan & Cunningham 2002).

Over time, it has become clear that a single course of treatment is simply not enough to meet the needs of a person in recovery from alcohol and/or other drug abuse. The field of

addiction treatment and recovery has been dominated by an acute-care model of treatment. This model focuses solely on treating the symptom, often using a brief, pre-packaged course of treatment e.g., 12 weeks of cognitive behavioral group therapy. This emphasis on sobriety only, however, has failed to meet the holistic and changing needs of people in recovery (White & McClellan, 2008; White & Tuohy, 2013; White, 2008). A new model, recovery-oriented systems of care (ROSC), defined as “networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders” (Sheedy & Whitter, 2013, p. 227), has been endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT). This new model is expected to best meet the needs of people in recovery because of its emphasis on supporting long-term recovery rather than simply focusing on abstinence from alcohol and other drugs. Although evaluation research is in its infancy and evidence for the effectiveness of the full ROSC model is currently limited, the defined elements of ROSC are empirically and theoretically rooted.

This new model is making its way into communities on the east coast of the United States (e.g., Philadelphia) and is gaining popularity (Flaherty & Langer, 2009). Connecticut was the first state to implement a full ROSC model starting in 1999 (Davidson et al., 2007), and statewide data provides support for its effectiveness and cost effectiveness (Laudet & Humphreys, 2013). This evidence includes a 24% decrease in expenses, 25% decrease in annual cost per client, 46% increase in number of people served statewide, 62% decrease in acute care, 40% increase in first time admissions, and 78% increase in outpatient care with 14% lower cost even with additional recovery support services (e.g., housing and transportation) (Kirk, 2010). Due to initial positive outcomes SAMHSA created an initiative, *Access to Recovery*, to grant

funds for other states to foster system transformation to a ROSC model similar to what Connecticut did (Laudet & Humphreys, 2013). The states of Georgia, Massachusetts, Michigan, New Jersey, New York, and Oregon are also in the process of transforming their systems to implement ROSC (Sheedy & Whitter, 2013). As communities begin to implement ROSC it is imperative to understand the barriers to transitioning out of the traditional, acute-care model. Flaherty and Langer (2009) put forth a call for research on recovery-oriented systems of care and the following questions were noted as some of the unfilled gaps in developing recovery-oriented systems of care.

“What needs to happen to transition from the acute-care model to a recovery-oriented system of care (ROSC) at the system level (e.g., statewide)? At the program level? Within the payment system (reimbursement structures)? At the clinical level (as it impacts services from clinicians and other service providers to individuals)?” (Flaherty & Langer, 2009, p. 15).

The current study will use in-depth qualitative interviews to explore the individual and systemic barriers and facilitators to moving from an acute-care model toward a recovery-oriented system of care model in a community mental health setting. A few key players are especially relevant to making this transition in a community: substance use therapists, probation officers, and administrators. Therapists and probation officers make direct contact with people going through substance use treatment and often collaborate with one another to share information and make decisions about services and interventions for the mutual client. Thus, these professionals act within the bounds of their professions, communities, workplaces, and values; they are also witnesses on the front lines of a client’s recovery. Administrators overseeing treatment and probation practices are key decision makers that have power to guide and promote change within

and between systems. By gaining insight from therapists, probation officers, and administrators we can better understand the barriers and facilitators on the ground level, both individually and systemically, to moving toward the ROSC model.

Conclusion

The problems associated with addiction to alcohol and other drugs are widespread in society. Treatment services for addiction have been helpful in reducing the costs and improving wellness, however, many treatment systems are not set up to treat addiction as a chronic illness. Recovery-oriented systems of care (ROSC), a proposed answer to this limitation, have existed on a small scale since 1999, but are now emerging in communities throughout the nation. In light of this shift in treatment systems occurring, the present study will use qualitative interviews of treatment providers, probation officers, and administrators to assess the barriers and facilitators of transitioning to a ROSC model of care.

Chapter 2 - Literature Review

Introduction

This chapter will summarize what is known about the traditional model of treatment for addiction, the acute-care model, and what we know about recovery-oriented systems of care (ROSC). I will also highlight literature showing the effectiveness of certain elements of the ROSC model, and the challenges discovered in implementing this type of care. Finally, this chapter will detail the present study including systems theory as a guiding lens.

Acute Care Model

Dependence on alcohol and other drugs has traditionally been treated as an acute illness, but when compared with type 2 diabetes, hypertension, and asthma on aspects of heritability, etiology, pathophysiology, and response to treatments it is better conceptualized as a chronic illness (McLellan, Lewis, O'Brien & Kleber, 2000). Understanding substance use dependence as a chronic illness has important implications for treatment practices, insurance authorizations, community support services, and aftercare (McClellan, et al., 2000). Until recently, the only mainstream approach to treatment of alcohol and other drug dependence has been the acute-care model. This model's defining characteristics include intervention prompted by crisis, brief treatment for purpose of stabilization, singular focus on symptom suppression (sobriety), decision-making dominated by the professional, short-term service relationship, and expectation of complete and permanent resolution of the problem post-treatment (White, 2008). Services in the acute-care model are delivered in a uniform series often consisting of screening, admission, initial assessment, treatment, discharge, and termination of the service relationship (White & McClellan, 2008). Because this model operates on the belief that treatment has resolved the

problem, re-entry into treatment is interpreted as a failure on the part of the individual rather than inadequate treatment design (White & McClellan, 2008).

Several problems exist with the acute care model including: low rates (10%) of people with substance use disorders actually entering treatment, less than 50% of clients successfully completing treatment, a lack of research-informed clinical practice, weak, if any, attempts made 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, and over half of people starting treatment having prior treatment with 19% having five or more prior treatment episodes (White & Tuohy, 2013). The acute care model also fails to attract people with lower levels of problem severity to enter treatment due to the treatment system's focus on a pre-defined goal of abstinence (White, 2008). Due to limitations of the acute-care model, multiple calls (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) have been made to change the addiction treatment model to one that can address the chronicity of addiction. Evidence of chronic care models can be found in treatments that 1) are able to "remove or reduce the symptoms of the disease, but cannot affect the root causes of the disease", 2) "require significant changes in lifestyle and behavior on the part of the patient to maximize their benefit", and 3) due to likelihood of relapse, "involve regular in-person and/or telephone monitoring of medication adherence, coupled with encouragement and support for pro-health changes in diet, exercise, and stress levels" (White & McClellan, 2008, p. 1). Although the acute-care model of addiction

treatment is better than no intervention at all (Moos, 2003), much of the field agrees that it is time to expect more out of our treatment model.

Recovery-Oriented Systems of Care

The paradigm shift toward recovery and recovery-oriented systems of care (ROSC) is a potential answer to filling the gaps left by the acute care model. In 2005, the Center for Substance Abuse Treatment (CSAT) gathered a group of stakeholders, consumers, policymakers, and clinicians for a National Summit on Recovery to create a common definition of recovery to lay the foundation for research devoted to better understanding this process (Sheedy & Whitter, 2013). From this meeting came a working definition of recovery, 12 guiding principles of recovery, and 17 elements of recovery-oriented systems of care; each of which were adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) (Sheedy & Whitter, 2013). These outcomes provide a framework and shared vocabulary for parties invested in learning more about the phenomenon of recovery: a “voluntarily maintained lifestyle comprised of sobriety, personal health, and citizenship” (McLellan, 2010, p. 201). ROSC is known for its emphasis on sustained recovery management, a coordinated multi-system approach, and flexibility to meet the individual’s needs (Sheedy & Whitter, 2013). Although treatment is only one system within a system of care, there are important implications for treatment services based on the principles and elements of ROSC. The following is a breakdown of these defining characteristics of the ROSC model as well as related research support.

Table 1: 12 Guiding Principles of Recovery (Sheedy & Whitter, 2013)

- | |
|--|
| <ol style="list-style-type: none">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.

(1) There are many pathways to recovery. This principle speaks to the unique, individual needs of people in recovery based on their own culture, context, and resources. Because of this, it is important to recognize that recovery is possible through multiple routes including, but not limited to self-help groups, professional treatment, and natural means. A system that follows this principle in action might extend reach to people outside of treatment by offering education in the community, whereas operations in an acute-care model wouldn't engage with people not in need of stabilization.

(2) Recovery is self-directed and empowering. Individuals and systems following this principle believe it is best to give autonomy to people in recovery as much as possible. While the acute-care model emphasizes professional-directed decision making, the ROSC model promotes acting in partnership with individuals seeking intervention and/or in recovery. Ultimately this principle recognizes that change must be wanted by the individual and executed by the individual (with support) for change to occur.

- (3) Recovery involves a personal recognition of the need for change and transformation.** The age-old saying that the first step toward change is awareness holds true for this principle. Without the individual's buy-in, no treatment intervention or recovery support service can be helpful to them. In the ROSC model, someone working with an individual in coerced treatment can use motivational interviewing to stimulate self-defined motivations for change instead of prescribing a pre-packaged treatment intervention as would be done in the acute-care model.
- (4) Recovery is holistic.** This principle widens the scope of intervention and encourages other professionals and services to be included in a person's recovery process. A person or system following this principle makes frequent referrals to medical doctors, nutritionists, housing aid, financial planners, clergy, etc. to give attention to the biopsychosocial and spiritual needs of a person.
- (5) Recovery has cultural dimensions.** Under this principle implementation of a ROSC model includes recognition that language, stigma, and historical context around a person in recovery will look different. The acute-care model does not properly account for this, but instead assesses a person's success or failure in the treatment program based on a uniform measurement (e.g., abstinence or "graduating" from a treatment group).
- (6) Recovery exists on a continuum of improved health and wellness.** This principle speaks to the recognition that recovery is not linear (Sheedy & Whitter, 2013), and that there are natural ups and downs related to long-term change. This could include relapses, but doesn't necessarily mean everyone will experience relapse. In a ROSC

model, people are not punished or shamed for setbacks and the ultimate goal is to improve overall wellness and balance in life.

- (7) Recovery emerges from hope and gratitude.** People in or seeking recovery find comfort knowing others have been through what they are going through, and many have overcome great obstacles. They recognize that change is possible for them and they acknowledge their gratefulness for what they have in recovery.
- (8) Recovery involves a process of healing and self-redefinition.** Under this principle it is understood that each person in recovery is making meaning of their process somehow, and must do so in order to personalize the change and gain positive outcomes from a holistic, healing process. The ROSC model promotes this meaning-making practice and gives freedom to the individual to direct it.
- (9) Recovery involves addressing discrimination and transcending shame and stigma.** The history of negative societal meaning and stigma placed on addiction is vast. Drug and alcohol related criminal charges can limit access to jobs, housing, and other resources including disability funds and services. The ROSC model is based on the belief that shame and stigma are hurting people in recovery and must be eradicated within the system of care. For individuals in or seeking recovery, internalized shame and stigma must be overcome.
- (10) Recovery is supported by peers and allies.** Recovery hinges on the social support given by others in recovery as well as friends and family. This network of people can provide encouragement, accountability, comfort, and hope throughout the recovery process.

(11) Recovery involves (re)joining and (re)building a life in the community. One must build back healthy aspects of their life after losing (or never having) certain resources that were difficult to obtain under previous circumstances. Within the ROSC model, an individual or system is meant to connect individuals to the aid they need for the rebuilding process whether that is finding proper housing, getting a job, or achieving a leadership role in the community.

(12) Recovery is a reality. Under this belief, treatment and other recovery support services are considered worthwhile because there is understanding that success in recovery has happened before and can happen again. In a recovery-oriented system of care, insurance companies and other funding sources allow payment for extended services, aftercare, and recovery supports in the community. Professionals working with people seeking recovery or in recovery hold hope that change is possible with the right ingredients for each individual.

Table 2: 17 Elements of Recovery-Oriented Systems of Care and Services (Sheedy & Whitter, 2013)

<ol style="list-style-type: none">1. Person-centered;2. Inclusive of family and other ally involvement;3. Individualized and comprehensive services across the lifespan;4. Systems anchored in the community;5. Continuity of care;6. Partnership-consultant relationships;7. Strength-based;8. Culturally responsive;9. Responsiveness to personal belief systems;10. Commitment to peer recovery support services;11. Inclusion of the voices and experiences of recovering individuals and their families;

12. Integrated services;
13. System-wide education and training;
14. Ongoing monitoring and outreach;
15. Outcomes driven;
16. Research-based; and
17. Adequately and flexibly financed.

Recovery-oriented systems of care are *person-centered* such that the individual has a tailored plan of care that matches their unique needs, culture, and problem severity. They are also *inclusive of family and other ally involvement* by way of involving family members in the treatment and recovery planning when appropriate. In the ROSC model, services are *individualized and comprehensive across the lifespan* in order to match the changing needs of a person in recovery over time. *Systems are anchored in the community* to provide people with a network of care and support to bolster their recovery efforts. *Continuity of care* is also characteristic of ROSC in order to provide a seamless transition of support from system to system in the community.

In the professional-client relationship, the focus is on developing a *partnership-consultant relationship* to increase decision making power of the client. Treatment and care in the ROSC model is *strength-based, culturally responsive*, and *responsive to personal belief systems* of the individual. Services are *integrated* and connections are made for individuals to access *peer recovery support services* during and beyond any treatment. *Ongoing monitoring and outreach* is an element of the ROSC model so that sustained recovery management is supported and tracked. Systems of care must be *outcomes driven, research-based*, and *adequately and flexibly financed*. To maintain the principles and elements of ROSC, *system-wide education and training* is necessary, including education for members of the community.

Further development and monitoring of ROSC *includes the voices and experiences of recovering individuals and their families* to make recovery services more accessible and relevant to the community in need.

Support for the Effectiveness of the ROSC Model

The research to date has established that addiction is a chronic condition (McLellan, Lewis, O'Brien & Kleber, 2000) that requires maintenance care beyond the crisis management provided in an acute-care model (White & McClellan, 2008; White & Tuohy, 2013; White, 2008). Several elements of the ROSC model have strong research support for their effectiveness in supporting sustained recovery including strategies for ongoing monitoring (Dennis & Scott, 2012; Scott, Dennis, & Foss, 2005), giving attention to improved overall health and wellness (Laudet & White, 2010), involving peers and allies for support (Atkins & Hawdon, 2007; Liddle, et al., 2008; Magura, 2008; McCrady, 2004), offering individualized and comprehensive services (Friedmann et al., 2004; Laudet, Stanick, & Sands, 2009), continuity of care (Chi et al., 2011; Ray, Weisner, & Mertens, 2005), responsiveness to personal belief systems (Avants, Warburton, & Margolin, 2001; Garrett & Carroll, 2000; Sheedy & Whitter, 2013), commitment to peer-recovery support services (Bassuk et al. 2016; Rowe et al., 2007), and integrated services (Friedmann et al., 2003; Friedmann et al., 2006; Parthasarathy et al., 2003; Weisner et al., 2001).

Table 3: Evidence of Empirical Support for ROSC Principles and Elements (Sheedy & Whitter, 2013)

Extensive research support in addictions field:

- There are many pathways to recovery
- Recovery exists on a continuum of improved health and wellness
- Recovery is supported by peers and allies
- Recovery is a reality
- Inclusive of family and other ally involvement

- Individualized and comprehensive services across the lifespan
- Continuing care within the continuity of care element
- Partnership-consultant relationships
- Responsiveness to personal belief systems
- Commitment to peer recovery support services
- Integrated services
- Ongoing monitoring and outreach

Modest research support in addictions field:

- Recovery is self-directed and empowering
- Recovery involves a personal recognition of the need for change and transformation
- Recovery emerges from hope and gratitude
- Recovery involves addressing discrimination and transcending shame and stigma
- Recovery involves (re)joining and (re)building a life in the community
- Systems anchored in the community
- Strength-based
- Outcomes driven

Limited research support in addictions field, but grounded in public and mental health fields:

- Recovery has cultural dimensions
- Person-centered
- Continuity of care
- Culturally responsive
- Inclusion of the voices and experiences of recovering individuals and their families
- System-wide education and training

Minimal research support in addictions, public health, and mental health fields:

- Recovery is holistic
- Recovery involves a process of healing and self-redefinition
- Adequately and flexibly financed

Although system-level models like ROSC are challenging to evaluate compared to individual programs, initial evidence points to the effectiveness of the ROSC model both city- and statewide (Kirk, 2010; Laudet & Humphreys, 2013). With the help of a large, *Access to Recovery* grant offered by SAMHSA in 2004, Connecticut turned an already-developing ROSC model into a thriving state-wide support for recovery (Kirk, 2010). This grant resulted in “the most significant gains in implementation of the ROSC in the entire period to date” (Kirk, 2010, p. 224). The first major impact was increased access to services with 18,000 people being served with over 40% being first-time admissions. Most people accessed services through probation, departments of correction, social services, and the faith community (Kirk, 2010). Diversity of individuals also increased: 41% African American, 40% Caucasian, 17% Hispanic; 60% male and 40% female (Kirk, 2010). Outcome data from 2003-2008 show a 46% increase in people served and a 24% decrease in the average cost per person (Kirk, 2010). This data provides initial evidence of both the care and cost effectiveness of the ROSC model implemented at the state level.

Another recovery model success story can be found in the Physician Health Programs (PHPs) in the United States, which have developed over the past 30 years to treat substance-use disorders (Skipper & DuPont, 2010). The PHPs protect both physicians and their patients by intervening with confidential treatment for physicians identified as having substance abuse problems. These programs, defined by early referral, evaluation, and long-term follow up and care management have a 79% rate of 5-year abstinence from alcohol and other drugs, and a 96% rate of physicians returning to work, with no evidence of harm to their patients (Skipper & DuPont, 2010). In a review of the past 5 years, 14% of physicians from the PHP had only one positive test for drugs or alcohol; on average, 85 random alcohol and drug tests were given to

each physician participating in the program over the five years (Skipper & DuPont, 2010). These Physician Health Programs are examples of the ROSC model being implemented at the system level. Based on examples of full ROSC model implementation highlighted in the literature, evidence suggests it to be fiscally beneficial, effective for promoting long-term recovery, and an improvement over outcomes associated with the acute-care model. Implementing the ROSC model can be a challenge, however, and initial findings show both individual and system-level barriers.

Challenges to Implementing the ROSC Model

What we know

The acute-care model has made a significant impact on how substance use treatment is viewed. Given that substance use treatment is cyclical in nature and the acute-care model functions as crisis management the current behavioral health care system has been challenged as an inadequate response to addiction (Kirk, 2010). Thus, the gaps in effectiveness of the acute-care model could propel a transition to the ROSC model. Funders, policy makers, and insurance agencies must be willing to endorse this new system of care, however, and agree to finance long-term recovery support services. Second, the need for consensus regarding the importance of addiction services as well as the mutual effort needed among community stakeholders (e.g., government, criminal justice, child welfare, and public health and safety systems) to provide those services can make implementation difficult (Kirk, 2010). Implementing the ROSC model requires multiple organizations to coordinate with one another and develop their recovery support services simultaneously. The effort and cooperation necessary to make the ROSC model a reality could be an unattractive venture for systems and programs comfortable with the acute-care model.

Making significant change within a large system often presents the challenge of overcoming resistance from individuals required to implement the change. Among behavioral health care systems that have begun to implement ROSC, having “too many agendas and too much to do” was identified as a concern of clinical staff (Kirk, 2010, p. 229). Many behavioral health professionals find themselves struggling to balance the multiple demands involved in helping people (Bakker & Demerouti, 2007). One study found that a barrier to implementing system-wide change was addressing the beliefs and values held by professionals that had been passed down to them by other providers such as having no tolerance for alcohol and drug use during a course of treatment, or viewing a strict expert approach as best practice (Boyle, Loveland, & George 2010). Holding different beliefs and values from those central to the ROSC model could be a significant barrier to necessary changes in tone, structure, and decision making required by individual professionals.

Developers of the ROSC model in the city of Philadelphia, PA created an initial framework for undergoing the transformational change necessary to implement the model in a community (Achara-Abrahams, Evans, & King, 2010). Transitioning to a recovery-oriented system involves a paradigm shift that includes greater collaboration between service provider and client. Thus, implementing the ROSC model becomes impossible without also changing attitudes of service providers (Achara-Abrahams et al., 2010). Further, stakeholders in Philadelphia realized that a system-wide change requires the direct involvement of each part of the system (e.g., people in recovery, service providers, regulatory agencies) rather than a traditional, top-down change process, in order to create lasting change (Achara-Abrahams et al., 2010). Another group implementing a recovery-oriented model in Illinois found that the changes they trained their staff to make were not sustainable without a change in infrastructure to

increase their organizations' capacity to support evidence-based practices (Boyle, Loveland, & George 2010). Further, this group clarified the need for follow up after training staff due to 1) supervisors failing to support all aspects of evidenced-based practice, 2) clinical staff defaulting back to the previous modes of service delivery, and 3) and minimal use of structured supervision to improve the skills of clinicians (Boyle et al., 2010). Similar to efforts made by people in recovery, transforming systems to a recovery-oriented model requires a desire to change, access to resources, support from other community members, and long-term management of the changes made. To understand the challenges that come with this type of change, it is necessary to assess what barriers exist at the level of the service providers and organizational leaders implementing their system of care.

What we need to know

The research to date highlights multiple structural and procedural limitations that require change in order to implement the ROSC model (Boyle et al., 2010; Laudet & Humphreys, 2013). Less is known, however, about changes necessary at the clinical level as it impacts services provided under the umbrellas of treatment and the criminal justice system. As the transition from an acute-care model to a recovery-oriented system of care advances, there is a continued need to address the beliefs and values held by staff (Boyle, Loveland, & George, 2010). Further, the need to understand how values and beliefs compare between systems and services (e.g., treatment and probation) is crucial for overcoming barriers to integrating these systems for full implementation of the ROSC model. It is necessary to identify the existing values and beliefs held by clinicians and organizational leaders operating under the acute-care model to assess fit with the ROSC model and barriers to its implementation. The current study will build on what is known by highlighting ideas and practices of individual service providers and organizational leaders that

could act as barriers or facilitators to the transformational change necessary in implementing the ROSC model.

Key Players

As communities begin to make the transition out of acute-care, a new sentiment is building: “all roads need to lead to recovery” (Davidson et al., 2007, p. 31). In their review of lessons learned in shifting toward ROSC, Davidson et al., (2007) argue that the focus of making this transition must be placed on changing policies, practices, procedures, services, and supports such that they are meant to promote recovery and that they in fact do so. Some key players must be considered when making efforts toward promoting recovery: therapists, probation officers, and administrators. From therapists and probation officers “daily decisions widen or narrow the doorways of entry into long-term recovery for those they serve” (White, 2008, p.3). Further, administrators have power to advocate for and lead their respective systems toward recovery-oriented practices.

For communities operating primarily from the acute-care model, the people involved in addiction treatment services are often participating by court mandate and in regular contact with both their therapist and probation officer. Criminal justice system referrals to treatment increased from 38% of total referrals in 1990 to 59% of referrals in 2004 (White, 2008) and remain steady with Alaska (53%), Iowa (52%), Montana (54%), Nebraska (57%), South Dakota (57%), Utah (53%), and Wyoming (51%) representing top percentages in the US in 2014 (SAMHSA, 2015). The professional system of care driving therapy and the professional system of supervision driving probation services are necessarily intertwined under conditions of a court mandate. Thus, it is essential to understand what factors within and between these systems could hinder movement toward recovery-oriented systems of care. Not only do therapists and probation

officers hold valuable perspectives for learning what barriers exist to implementing a ROSC model, but they also hold critical roles in following through. Administrators overseeing these two systems have perspective on the outside forces at play that limit their ability to implement certain changes in and between the two. The beliefs and values held by administrators also influence the effort they put behind ensuring system-wide changes are implemented. Together, probation officers, therapists, and administrators in these systems play an essential role in the implementation of services provided.

Systems Theory

Systems theory is a useful guide for understanding the influence individuals, agencies, and communities have on one another. It is also a helpful theory for explaining what is necessary for change to occur like a transformation to the ROSC model. This theory has four basic assumptions: 1) system elements are interconnected, 2) systems can only be understood as wholes, 3) all systems affect themselves through environmental feedback, and 4) systems are not reality, but rather heuristics (Klein & White, 1996). In identifying a system, the only necessary element is that it has an effect on its environment (Klein & White, 1996). When considering the systems involved in a single community, we can acknowledge that individuals in active addiction or recovery have impact on their families and friends and those people in turn have an impact on them. We also know that individuals working in agencies behave in certain ways based on the expectations passed down from the systems they are involved in, including the educational systems where they were trained, the agency where they work, or an outside entity governing the agency.

When it comes to change, systems theory presents the role of “variety” or “the extent to which the system has the resources to meet new environmental demands or adapt to changes”

(Klein & White, 1996, p. 159). In the case that a system has a rigid set of rules and minimum flexibility around those, it will be difficult for change to occur without a break in the system (Klein & White, 1996). Feedback loops within systems will either promote change or prevent change based on the type of feedback coming from parts of the system, however the system is always working toward homeostasis to maintain a status quo (Klein & White, 1996). In systems theory, *positive feedback* will make reaching a goal less likely while *negative feedback* will help the system reach homeostasis (Klein & White, 1996). Systems are often composed of subsystems that operate within the larger system and with other subsystems (Klein & White, 1996). Family examples could be sibling, parent, and parent-child subsystems while community examples could be citizen, court, treatment, family, and service provider-client subsystems. In order for system-wide change to occur, all subsystems would have to allow for variety within and between systems as well as monitor any deviation from the goals of the system (Klein & White, 1996). In the transformation toward ROSC, this would require cooperation from each subsystem and would have to be supported actively with checks and balances from each level of the system.

Present Study

Although addiction is pervasive in our society, substance use treatment has been useful in reducing its impact. The literature to date notes significant limitations, however, in the effectiveness of this current treatment model in supporting long-term recovery. Research has unveiled gaps in the acute-care model such as short duration of treatment, low rates of entrance into addiction treatment and low rates of treatment completion, and minimal or a lack of follow up services (White & Tuohy, 2013). A new model, recovery-oriented systems of care, is a promising response to fill these gaps, but has yet to be widely practiced and rigorously evaluated. As the transition into ROSC takes place with financial supports from the Substance Abuse and

Mental Health Services Administration (SAMHSA) it will be important to understand the barriers to moving out of the acute care model. Mandated substance use treatment is a common source of influence on client engagement in the current community response to addiction. This sub-system of services has promoted engagement between substance use therapists and probation officers for the case coordination of mutual clients in treatment. The goal of the present study is to understand the current facilitators and barriers to transitioning from an acute care model to a ROSC model on two levels: the individual level of the professional providing services as well as the systemic level of policies and procedures currently in place within treatment and probation settings. Using qualitative analysis, the present study seeks to answer the following research questions:

1. Do the ideas and practices of 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?
 - a. Where do these ideas and practices 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?
 - a. What are the professional beliefs and organizational values that act as barriers to implementing the ROSC model in an addiction treatment community?
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?

Conclusion

The acute-care model has been a generally positive response to the problem of addiction, however, it does not provide maximum benefit to clients based on what we've learned about addiction as a chronic condition. The conversation regarding treatment models is changing to focus more on ways to enhance treatment such that it supports long-term recovery. Recovery-oriented systems of care consists of defining principles and elements of practice that are grounded in research and theory. Initial evidence points to the effectiveness of this model in reducing costs and increasing access to treatment and recovery services. Despite this strength, there are challenges in fully implementing this model that are left to address. Using key players in the treatment community and systems theory as a lens, the present study answers three main research questions regarding the barriers and facilitators of transitioning to a ROSC model.

Chapter 3 - Method

Introduction

This chapter will provide an in depth overview of the present study's methods. This will include the procedures and participants, research team recruitment and training, data collection, analysis, efforts in trustworthiness, and reflexivity. It is essential to highlight the human strengths and limitations in qualitative research and this chapter will begin the discussion on these aspects of the study.

Procedures and Participants

With IRB approval, semi-structured individual interviews were used to gather qualitative data on the facilitators and barriers to transitioning to a ROSC model on the individual level of the professional providing services as well as the systemic level of policies and procedures currently in place within treatment and probation settings. Using purposive sampling methods, I 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. The treatment professionals included substance use therapists working with clients in treatment (self-referred or court-ordered) and treatment administrators supervising therapists and overseeing services at their agency. The probation professionals consisted of officers supervising offenders by court order, administrators supervising officers and overseeing agency services, and an addiction-based case manager connecting clients to community resources.

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, however, from distinct supervising agencies including Diversion, Court Services, Community Corrections, and Parole. Agencies managing Diversion and Court Services are largely governed by the state, whereas Community Corrections and Parole are underneath the federal Department of Corrections. The sample was gathered in the Midwest throughout an urban area (population over 50,000) and nearby rural communities. From this effort, I recruited nine substance use treatment professionals (7 substance use therapists, and 2 substance use treatment supervisors) and nine probation professionals (5 probation officers, 3 probation administrators, 1 addiction-based case manager). It is unknown why some chose not to participate since the only responses I received were to confirm a willingness to participate.

Demographic information was obtained to describe some background information of the participating professionals (See Table 4). The average age of treatment professionals in the sample was 37 while the average age for probation professionals was 43. Seven of the participants were males and 11 were females. The average number of years treatment professionals reported being in their profession was six and the average was 20 for probation professionals. Professionals were interviewed individually, and asked open-ended questions to evoke ideas and practices related to defining properties of the ROSC model and acute care model (See Appendix A for a complete list of interview questions).

Research Team

Data entry and analysis were completed by members of a research team including the primary investigator, three undergraduate students, and one Master's student. All team members completed the mandated university training modules necessary for conducting research. Team members were also trained in the interview transcription process, basic qualitative analysis, deductive coding procedures, and cross coding practices.

Recruitment to Research Team

To recruit research team members to help with data entry and analysis I created an announcement explaining the study, the research tasks to be completed by team members, and a request that interested students email me their resume and a brief note expressing their interest in the project. I contacted key personnel in the School of Family Studies and Human Services, the Psychology Department, and the Criminology Department to distribute the announcement. Additionally, I emailed students from classes I taught in previous semesters with the announcement. From these efforts, I received four responses. I met with the four undergraduate students to orient them to the project and assess their willingness and availability to help with the transcribing and analyzing procedures. One student decided to opt out based on having too many prior commitments. The undergraduate team members consisted of one Freshman in Psychology, and two Juniors in Family Studies and Human Services.

The fourth research team member was a Master's student in the Social Work program at a nearby University. This student was doing her internship at the community mental health organization where I recruited therapists. She expressed interest in gaining research experience early in her internship and was referred to me by her supervisor. The supervisor and intern agreed that research would be part of her internship experience, which allowed her to work on this research project with me during her internship hours. She completed the same trainings that were expected of the undergraduate students.

Research Team Training

Having my own qualitative research training and some prior experience conducting qualitative research, I provided training to all research team members prior to and throughout data transcription and analysis. Initially I provided basic training on qualitative research to orient

the team members to the goals of the project. I also provided background information on the basis for my main research questions. Trainings were provided both one on one and in group settings. I provided skills training to the team members prior to each new step including transcribing interviews, deductive coding, and cross coding. Each team member had the chance to practice the skills with me prior to completing the tasks on their own. For example, prior to coding the data, I provided team members material to reference as they learned the deductive categories, allowed them to observe my coding, and instructed them live while they practiced coding within these categories. All practice was done with data from the present study to increase familiarity and comfort for the team members.

Data Collection

Semi-Structured Open Ended Interviews

All participants were interviewed individually by the primary investigator. This promoted a similar interview experience for each participant. Interviews lasted approximately one hour, but ranged from 35 to 77 minutes. I used an interview guide (See Appendix A) 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 for analysis. Research team members transcribed the interviews and were instructed to review each of their transcribed interviews a second time to catch any errors. After this, the team members turned in their transcripts to me and I reviewed them for a third time to correct any transcription errors.

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. Although the Master's student intern agreed to maintain confidentiality and uphold all ethical standards related to the research process, she only had contact with interviews of professionals outside of her building to aid in privacy efforts. To maintain privacy, all participants have been provided pseudonyms that are used throughout this manuscript.

Analysis

To answer the research questions, interviews were transcribed verbatim and coded for themes using a deductive approach. Directed content analysis (Hsieh & Shannon, 2005), was used to create initial codes from the theory and research-based elements of both recovery-oriented systems of care and the acute care model. First, research team members and I went through the transcripts and identified all text that seemed to describe either ROSC or the acute-care model. We then sorted the identified text into the predetermined codes representing the two models (Hsieh & Shannon, 2005). These steps were also taken to identify and sort facilitators and barriers. Sentences were established as the meaning units of analysis in this study. It was possible that meaning units could be coded more than once when there was overlap of fit in the predetermined codes. For example, a participant might describe a recovery-oriented practice that is both person-centered and inclusive of family and other ally involvement.

Professional and organizational practices and ideas were coded as aligning with ROSC or the acute-care model characteristics. Ideas and practices aligning more with the ROSC model consisted of descriptive language such as "fluid, client-centered, long-term, clients, connected to resources, collaboration, and recovery." Whereas ideas and practices aligning more with the

acute care model consisted of descriptive language such as “offenders, sobriety, short-term, assigned expectations, and medically necessary.” Barriers and facilitators to transitioning to a ROSC model were captured by asking in the interview about ideal versus actual experiences related to the professional’s practices, and coding meaning units according to the predetermined codes.

After this initial coding process the research team members and I met to evaluate mismatching codes and determine an appropriate consensus. As the 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. Thus, each transcript was analyzed by two coders. Each undergraduate team member coded five interviews and the Master’s student coded three.

After initial codes were determined, another round of deductive coding was completed to identify the sub-categories of the content coded as aligning with either ROSC or acute-care and content coded as either a facilitator or barrier. Text that seemed to describe an individual or systemic factor contributing to the initial code was sorted as such. Additionally, text coded as either ROSC or acute-care was reviewed and deductively coded for specific characteristics of the models described within the text (e.g., client-centered, or brief).

Trustworthiness

Analyst Triangulation

With the help of my research team members, it was possible to practice analyst triangulation such that all data was analyzed by two different people. I analyzed each interview and partnered with a team member who had a set of interviews to analyze. We did the analysis separately and came together to cross code and reconcile differences in codes. This practice

helped to increase accuracy in coding and capture a higher percentage of the existing data that would have been missed otherwise by human error.

Accountability for Biases

Another form of trustworthiness implemented during data analysis involved holding team members accountable for personal biases. When meeting as a research team we would often discuss reactions to the interview transcripts and I shared reflections on how I experienced the interviews in person. We would acknowledge our biases and discuss alternative interpretations of the interview. To encourage critical self-reflection, I asked each team member to write a brief reflection paper on how they experienced the interviews, what biases they noticed, and to detail their level of familiarity with the subject matter prior to data analysis.

Member Checking

To further increase credibility and trustworthiness of the data, member checking procedures were conducted. At the end of analysis, I selected key informants to test the overall interpretation of the data and verify that the final representation of the data accurately captured their lived experience (Lincoln & Guba, 1985). I invited one male treatment administrator, one female probation administrator, one female treatment provider, and one male probation officer to be my key informants for the data. These contacts were chosen to maximize the perspectives placed on the data. Administrators in my sample had a broad view of the systems at play whereas the service providers had a detailed view of the lived experience within the systems. I invited the four contacts also based on their positions at different agencies in the community. All four of these professionals agreed to help. I held individual meetings with these informants and first told them of my research questions and characteristics of both the ROSC and acute-care models. I then reviewed with them a summary of the end data highlighting the results of model alignment

as well as specific subthemes of barriers and facilitators that emerged for their professional group. The informants had an opportunity to comment on the accuracy of the findings and ask questions. Each informant expressed agreement that the results fit their experiences and offered follow up thoughts in response to the results.

Researcher Reflexivity

A qualitative researcher acts as the instrument by which data is analyzed. It is only appropriate to make known the position of the primary investigator as well as all team members who had a part in analyzing the data (Goldberg & Allen, 2015). Important to this study, reflexivity offers insight into the investment or stake the researcher has in the research (Dickie, 2003). As the primary investigator, I will detail my background, involvement with, and relationship to this research. I will also provide information on the research team members who worked with me on this project.

As the primary investigator, I conducted and analyzed all 18 interviews. I am a Caucasian female originally from a rural community. I am a licensed substance use therapist myself and I knew each treatment professional I interviewed as they were coworkers at the time. My undergraduate degree was completed in Psychology and my graduate training was in Marriage and Family Therapy. I am trained as a systems thinker and I continue to be informed by this theory as a licensed Marriage and Family Therapist. I am considered an outsider to addiction as I have never personally gone through a process of recovery from alcohol or other drugs.

I worked in a substance use treatment setting for three years, and I had experience collaborating with probation officers in the area. I did not know all the probation officers prior to interviewing them, however. I was much closer in relationship to the treatment professionals compared to the probation professionals. This closeness likely allowed the treatment

professionals to open up more freely about their perspectives as trust and rapport had been built over time working together. It is possible the probation professionals filtered their answers more due to lack of time together for building rapport. In a few of the interviews with probation contacts I perceived that when my status as a therapist was known it may have instilled caution in the participants who might have had experience with therapists working in opposition to common probation practices such as being unwilling to report when a client has admitted to use in a therapy session. Alternatively, this perceived caution could be informed by the stigmatization of probation officers as harsh or cruel. I also became aware of my position as a researcher in relation to some of the probation contacts. In a few interviews with probation professionals I recall wondering if the participants practiced caution because since I was conducting research there was a sense that “I must know more than they do about certain topics”, such as best practices.

At this stage in my development I do hold a bias that recovery-oriented systems of care provides a fitting response to the needs in our communities related to substance abuse and dependence. I do perceive that not all systems in the communities involved in this research are set up to support a recovery-oriented value. I also went into this research anticipating that certain probation professionals would not be informed by a recovery-oriented perspective and that their stance on change could be a limitation in the possible movement toward recovery-oriented systems of care. I also anticipated that treatment providers would have individual values most likely matching the recovery-oriented perspective. In my training of the research team members I was deliberate in balancing my bias with information on the effectiveness the acute-care model and how the system is not necessarily broken, but rather not at its optimal level of functioning for the needs of people dealing with addiction. To provide reflexivity of the research team I asked

each team member to write a reflection on the biases they hold and how they reacted to the data as they encountered it.

My research team consisted of two females and two males, all identifying as Caucasian. The Master's student was practicing clinical work on internship with clients seeking mental health treatment at the time of the data collection and analyzing phases. None of the team members have had personal experience with addiction. The undergraduate team members identified that they knew very little about therapists, probation officers, or the clientele beyond basic understanding. One team member acknowledged that he established a preference for calling a person "client" rather than "offender" after transcribing his interviews and noticing a difference. He also noted feeling a bias toward recovery-oriented systems after completing this research. Another team member identified that she expected the probation professionals to have more alignment with the acute-care model in contrast to ROSC due to an assumption that probation officers would be "rigid and stern". She reflected being surprised that probation officers did express care for their clients and most held several ideas in line with recovery-oriented services. Another student reflected that he could have been influenced by first transcribing an interview that was largely recovery-oriented as he found himself drawn to those characteristics.

Conclusion

Using semi-structured, individual interviews, the present study addressed the ideas and practices of treatment and probation professionals and how these fit within the ROSC and acute-care models. Each transcript was analyzed by myself and another research team member. Trustworthiness was gained through reflexivity, member checking, accountability for biases, and analyst triangulation.

Chapter 4 - Results

Introduction

This chapter provides a breakdown of the results organized by research question. Each research question will have results specific to the deductive codes including ROSC principles and elements, individual and system-level barriers, and individual and system-level facilitators. Results from the directed content analysis are presented using counts and percentages with supplemental exemplar quotes from the data to add voice.

Themes described as either ‘dominant’ or fitting for ‘almost all participants’ are designated when eight to nine of the particular professional group members (treatment or probation) mentioned a theme or sub-theme. If four to seven of the professionals mentioned a theme, it is designated as a ‘main’ theme, and if three or fewer participants mentioned a theme, I say ‘some’ participants. Refer to Tables 5.1 and 5.2 for a summary of the results.

At the end of each interview I asked the participant if they had ever heard of the acute care model and the recovery-oriented system of care model. Of the 18 participants, seven of the nine treatment professionals and five of the nine probation professionals identified having heard of the acute-care model before while six of the nine treatment professionals and three of the nine probation professionals identified having heard of the recovery-oriented systems of care model. None of the participants identified being able to fully describe the models, and most believed they recognized the model names from trainings or textbooks. Although participants did not necessarily have a description for these terms, almost all participants mentioned more themes aligning with recovery-oriented systems of care than those aligning with the acute care model as detailed below.

Themes from Research Question 1

Findings from the first research question reveal whether treatment professionals and probation professionals align more with recovery-oriented systems of care (ROSC) or the acute-care model in their ideas and practices described. It also gives us evidence for whether this alignment is associated with individual or larger system factors. All treatment professionals interviewed and eight out of nine probation professionals expressed greater alignment with the ROSC model than the acute care model. Of all the meaning units for model alignment, 83% aligned with ROSC and 17% with acute-care. Of the meaning units coded as ROSC, 52% were from treatment professionals and 48% from probation professionals. Of the meaning units coded as acute-care, 30% came from treatment professionals and 70% from probation professionals.

Themes of model alignment were coded as representing either individual-level (e.g., “for me, personally”) or system-level (e.g., “the way we were trained”) factors. Some alignment themes were coded as representing both individual and system-level factors (e.g., getting supervisor’s approval for involving family members). The meaning units coded as subthemes were pre-determined based on the characteristics of each model, which are detailed below. Of all the meaning units coded as ROSC, 77% were associated with individual-level factors. Treatment professionals contributed 55% of the meaning units coded as individual-level (9/9 participants), ROSC while probation professionals contributed 45% (9/9 participants). An example of ROSC alignment at the individual level is demonstrated with the following statement by Jolene, a substance use therapist who said, “You know I feel like if the client doesn't set the goals we're doing them a disservice. I could have the best treatment plan goals ever and if it's not aligned with what the client wants then I don't really know what the end of the deal we're working for.” Roger, a probation officer, also describes alignment with ROSC on an individual

level stating, "I'm a big fan of 12 step community, I think if you do it right and you participate in it correctly, you know having a sponsor is the most fantastic thing they have."

Of all the meaning units coded as acute-care, 52% were associated with individual-level factors. Treatment professionals contributed 22% (7/9 participants) of the meaning units coded as individual-level acute-care while probation professionals contributed 78% (7/9 participants). An example of an acute-care code at the individual-level can be seen in a statement from Jerrod, a therapist, stating, "I don't take a lot of, I'm not very lenient right now with people. Especially, um, y'know if they show me signs early on that this is not a priority for them." Another example comes from a probation administrator, Justin, describing his personal take on challenges related to people who continue to use while on probation and in treatment:

I think sometimes my personal opinion, the old, granted it's an issue that can't just be totally broke. I think sometimes some counselors can give too much of an easy pass on use and "well you know, everybody relapses, it's a process." I think offenders are smart, they pick up on that, and they use that "Well you know, everybody relapses."

Of all meaning units coded as recovery-oriented 23% were associated with system-level factors. Treatment professionals contributed 34% (9/9 participants) of the meaning units coded as system-level factors and probation professionals contributed 66% (9/9 participants). An example of a system-level ROSC code can be found in a statement from an addiction-based case manager, Greg, "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." A treatment administrator, Drew, gives a system-level example of ROSC when he states, "Let's make sure we have staff that are trained and good at their jobs and they're trying to

use evidenced based curriculum, trying to keep some of that curriculum fresh and new and not just always going off of what's ten or twenty years old.”

Of the meaning units coded as acute-care, 48% were associated at the system-level. Treatment professionals contributed 37% (7/9 participants) of the meaning units coded as system-level while probation professionals contributed 63% (9/9 participants). An example of this can be seen in a statement by a treatment administrator, Emily when she states, “and all the powers that be aren't going to authorize outpatient treatment for a year.” Another statement from Alison, a probation administrator, captures acute-care at the system level:

So if somebody's using and, it's our district wide practice that if you submit a positive drug test you are gonna go to jail for two days. The next one two days and then the next one three days. Um, y'know if you are using and actively using, that is not gonna change your behavior, that is not a motivator or a catalyst for change. "Okay, I can do two days, then I'll come out and get high."

ROSC Principles as Subthemes

To best understand the nature of the alignment toward a recovery-oriented system of care, I will present the findings related to the particular characteristics of this model. Meaning units coded as ROSC principles contributed 37% to the total amount of meaning units coded as ROSC in the data. Treatment professionals contributed 56% and probation contributed 44% to the total 507 meaning units coded as principles.

Many pathways. This ROSC subtheme emerged 28 times, representing 2% of the ROSC codes. Treatment providers contributed 79% (8/9 participants) of the codes while probation professionals contributed 21% (3/9 participants). Roger, a probation officer, spoke to this theme stating, “That's the beauty of probation slash human science, social science, is you can have a

rough outline and get 47 different paths to the same finish line.” A substance use therapist, Elizabeth, in reference to what she tells her clients stated, “Now whether or not you want to take my road or you want to take your own road I said either way we're eventually trying to get to the same end.”

Self-directed/Empowering. This subtheme had 140 meaning units, representing 10% of the meaning units coded as ROSC. Meaning units from treatment providers account for 62% (9/9 participants) and meaning units from probation professionals account for 38% (8/9 participants). An example from a probation officer, Cole, highlights how he communicates this idea to his clients:

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.

Another example comes from a substance use therapist, Deacon, who describes his role in helping clients become empowered:

..... 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.

Recognition of need for change. This ROSC subtheme came up 40 times, representing 3% of the ROSC data with 52.5% of the meaning units being from treatment providers (8/9 participants) and 47.5% of the meaning units being from probation professionals (8/9 participants). Referring to her clients, Elizabeth, a substance use therapist, states, “Yeah, so the

end is that ah ha moment where they realize that there is something. That there is something there, whether there is trauma that needs to be healed or whether they're at that point where they're like I'm ready for recovery.” Talking about catalysts for a person on probation to finish successfully, Roger, a probation officer, says, “But as far as being done done, you know, their just needs to be that ack--probably the biggest thing is that acknowledgement that something's going wrong and then the willingness to work on it.”

Holistic. From the data, this ROSC subtheme emerged 116 times, representing 8% of the meaning units coded as ROSC with meaning units from treatment providers (9/9 participants) accounting for 47% and meaning units from probation professionals (9/9 participants) accounting for 53%. Emily, a treatment administrator, said,

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.

Offering her perspective as a probation professional, Lily provided her thoughts on prioritizing needs within a holistic perspective, stating, “I guess I would say having stable housing and employment are usually the first two things that we usually work on. And then after that it's just whatever they need, whether it be mental health or substance abuse, it's typically one or the other.”

Cultural dimensions. This subtheme emerged just five times, representing 0.4% of the meaning units coded as ROSC with 80% of the meaning units coming from treatment professionals (2/9 participants) and 20% coming from probation professionals (1/9 participants).

Claire, a substance use therapist, talked about her process for getting to know the client's context:

I think for me I still like to have a good context of like where the clients come from, so I pretty much always do a genogram with clients, just helps me, I'm a very visual person, helps me see where they came from or if there are issues with, also clients have been adopted I've run into that, or were raised in a family that wasn't that like, y'know just a mother and father, and so just kind of, and just thinking of all that context and where they come from is really helpful for me just starting, so I usually do that, I usually identify who in your family had substance problems, and just helps me kind of have a good picture of them.

Hazel, a probation administrator, talked about the value of culture in the community around their services:

But some of the benefits that come within the community is that transient nature as well. Is sometimes, having that exposure to different cultures, and different ways of thinking, and not just like racial cultures, but a lot of different cultures within those subcultures. I think the community is very accepting of a lot of things.

Continuum of improved health. This ROSC model subtheme appeared 82 times, representing 6% of the meaning units coded as ROSC with an even split of meaning units from treatment professionals and probation professionals (18/18 participants). A helpful description of this theme was provided by a therapist, Jolene as she compared substance use treatment to other health services:

I look at it and I always try to pose it as, it's a great opportunity, depending on how you respond to what you perceive as a setback or a failure. One I think it's just like our

health, there's wellness checks annually for a reason, we were healthy last year, that doesn't mean that things haven't changed in some way between that time to now. So when somebody is coming back through treatment it's like you don't know what you know until you know it. You know when you left you knew all of these things, you didn't lose a single one of those skills, strengths, or abilities in the process of having a lapse or relapse, you're still bringing them to the table, it just seems like we might have missed some things, it's like a blueprint, here's our plan for building this house and we're like oh crap we missed this part let's put that in there or let's rearrange this and put it over here. So I feel like it's a positive thing when clients are coming back through treatment cause it's telling us we need a checkup, we need to maybe change some things so that you're healthier overall and for a longer term.

Emerges from hope. This subtheme emerged 15 times, representing 1% of the meaning units coded as ROSC with meaning units from treatment professionals (4/9 participants) accounting for 40% and meaning units from probation professionals (6/9 participants) accounting for 60%. An example comes from Emily talking about the role of the therapist saying, “I think that our obviously the biggest role is treatment, teaching coping skills, but I also see us as the facilitator of hope, I think that that's what we are, is that there's a hope for something different, a hope for something better for them.” Lily, a probation officer, talked about how clients can find themselves ready for change when someone places hope in them:

“Finding that thing that motivates them, again that's different for everybody some people it's enough, their kids, but some people that's not enough for them. And then like I said sometimes it's just having that person believe in them that they can do the right thing and make the right choices...”

Healing and self-redefinition. This ROSC subtheme occurred 20 times, representing 1.4% of the meaning units coded as ROSC with meaning units from treatment professionals (5/9 participants) accounting for 65% and those from probation professionals (5/9 participants) accounting for 35%. Elizabeth differentiated therapy from probation stating, “Cause I'm a little bit different than other therapists. But I think it's because I'm an MFT. Cause I look deeper, I don't just go did you use, did you use? And that's what I tell my clients you know I'm I'm not your PO I'm your therapist, let's heal that wound.” Another example of this theme came from Hazel talking about what informs the priorities of probation as she stated, “You're talking about individuals that have probably faced incredible traumatic events in their lives. Especially in drug and alcohol addictions, if it's self-medicating to help get them through those types of things, is there an underlying mental health issue?”

Transcending shame and stigma. There were 19 total accounts of this subtheme, representing 1.4% of the meaning units coded as ROSC with meaning units from the treatment sample (6/9 participants) making up 95% and meaning units from the probation sample (1/9 participants) making up the other five percent. An example of this subtheme comes from a substance use therapist, Janice, describing how she responds to clients after relapse stating, “And I always tell my clients that you know, if you relapse or you have to start over it's a learning experience and not like something to be ashamed of or beat yourself up about. You figure out what can I learn from that and move on.” An example from Cole, a probation officer, and his experiences seeing clients get stuck in unhelpful thinking patterns reflected that, “And then getting them to understand it's okay to be asking for help. A lot of them struggle with that, you know, it's--no, no, I'll just do this on my own, cause they've never had that support or, you know, guidance to hey go ahead and reach out.”

Supported by peers and allies. This ROSC subtheme emerged 12 times, representing 0.9% of meaning units coded as ROSC with 75% of the meaning units coming from treatment professionals (9/9 participants) and 25% of meaning units coming from probation professionals (2/9 participants). Alison, a probation administrator, talked about the approach at their probation agency stating, “We're big into natural resources, meaning kind of who is in that circle with them, so family, um whoever it may be that is closest to them is super key to their success.” Greg talked about his role as an addiction-based case manager and how this uniquely set him up to be supportive to the client:

Um, and that's kind of neat cause they don't see it as any sort of other agenda or y'know um, and then they can start to feel some of the ramifications of that, "oh wow, he did, he said he was gonna help me get connected with food and sure enough he, not only did he get me connected with them, y'know my car broke down he drove me down there to get it" y'know that kind of stuff that I like to help clients see that, and maybe this is weird but just see that the world doesn't have to be shitty, y'know? People don't have to be crappy to each other, and um, just a sense that people do genuinely care, and not just because they're paid to like they can go above and beyond that and I think my role allows me to kind of surprise clients in that way sometimes instead of being so rigid about things. So I like that.

(Re)joining/(re)building life in community. This subtheme emerged 27 times, representing 2% of the meaning units coded as ROSC with 22% of the meaning units coming from treatment professionals (5/9 participants) and 78% coming from probation professionals (5/9 participants). Claire, a substance use therapist, reflected how important the community around an individual in recovery can be:

Definitely like changing your friendships. I think that's so important and it's so hard right, cause so many clients especially if they grew up in the community like, this is where they made friends, you just ask someone to like "well you need to stop hanging out with them" y'know? Um, but I think that the most successful changes have happened in clients who are willing to do a 180, and y'know clients will come in and say like "change my people, places and playgrounds" right and that's so important, if you're continuing to hang out on the streets where you got your drugs and you use your drugs you're not gonna be successful long term.

Lily shared her main goals as a probation officer and how it revolves around connecting them back to the community stating, "so we supervise people who get out of prison, and we just meet with them and try to encourage them to keep a job, housing, and not to of course commit more crimes, and be pro-social."

Recovery is a reality. This subtheme occurred just 3 times, representing 0.2% of the meaning units coded as ROSC with 33% of the meaning units coming from treatment professionals (1/9 participants) and 67% coming from probation professionals (2/9 participants). As an addiction-based case manager, Greg has been able to witness success in recovery stating, "So she's just not gonna allow things to go back to where they were. She talks about getting her kids back and those sorts of really impactful things that she's seen that are attainable now, um, so that's neat to see too." Another example to highlight the belief that recovery is a reality comes from Claire, a therapist, Claire when she shared a story about a client in recovery:

When he came back a couple months later and I saw him then for about six months probably and, he was really really active and um, in our sessions and knew what he wanted to accomplish, he was staying clean, he was going to NA in the community and

so just really involved in that and so involved so that he would like do activities with like [other cities'] NA communities which was really cool to see

ROSC Elements as Subthemes

Meaning units coded as ROSC elements contributed 63% to the total meaning units coded as ROSC in the data. Treatment professionals contributed 50.1% while probation professionals contributed 49.8% with a total of 874 meaning units for elements.

Person-centered. This subtheme emerged 196 times, representing 14% of the meaning units coded as ROSC with meaning units from treatment providers (9/9 participants) accounting for 57% and probation professionals (9/9 participants) accounting for 43%. This subtheme was the most frequent ROSC characteristic in this study and was well-represented in both the treatment and probation samples. Demonstrating a person-centered service, Drew, a treatment administrator, stated, "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." Similarly, Abby, a probation officer, described how she works to keep her focus on the individual:

And so I try to not feel that way or think that way, um, so that's maybe something that plays in there too is okay, we need to just step back and, and not judge or not put assumptions in, I don't really judge but, put assumptions in and maybe just try to start where that person is and not just make the presumptions or assumptions uh based on age or circumstance

Inclusive of family and allies. This ROSC subtheme was found 49 times, representing 4% of the meaning units coded as ROSC with 82% of the meaning units coming from treatment professionals (8/9 participants) and 18% of the meaning units coming from probation

professionals (4/9 participants). An example of this subtheme from Emily, a treatment administrator, came out of her wishful thinking when she said, “Services to the family I think is something that I would like in an ideal situation, that I would like to have a group that where people can bring in their family members.” Alison, a probation administrator, highlighted the changes her probation agency has made since learning about the effectiveness of getting others involved:

And so now because of all the evidence, my supervisor who does their program intake asks them "who is on your team, who do you want to be on your team," and we get a release from the get go, so that we y'know if they're wavering and we know that y'know it's a positive situation, even parents, even y'know whomever and we get that release up front, because they have identified that person or those persons as being important in their success.

Individualized and comprehensive services across the lifespan. For this subtheme I found 118 occurrences, representing 9% of the meaning units coded as ROSC with 53% of the meaning units coming from the treatment professionals (9/9 participants) and 47% coming from the probation professionals (9/9 participants). Michaela, a substance use therapist, shared how she tailors treatment to the individual using the stages of change saying, “Oh, of course every client is different, and it depends on their, what stage of change they're in. So if someone is just pre-contemplating, that's totally different than someone who's taking action. So, you start wherever they are.” An excellent example of this theme came from Emily, a treatment administrator, as she discussed the idea of people cycling back to treatment:

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.

Anchored in the community. A total of 67 meaning units emerged for this subtheme, representing 5% of the meaning units coded as ROSC. Of the meaning units, 39% came from treatment professionals (8/9 participants) and 61% came from probation professionals (8/9 participants). In reflecting on what he would want in his ideal situation as a therapist, Jerrod said, "I might meet them in like public settings. Go on walks, yeah be a little more, not so professional, 'come to my office' type thing. I think that would be helpful, if they felt more comfortable, like, yeah human." From thinking up ideals for her probation agency, Alison identified a service she would prefer that reflects this subtheme:

It would be more of an employment specialist, but in my dream, I would have somebody who would be able to go out and make relationships with businesses, make that connection get that relationship going, and sell if you will our clients to local employers as far as the benefits of hiring them, and they would have time nurturing that relationship, and so if they hired three of our offenders, then that person is the contact if they don't show up for work. We are a support system for the employer, like that would be my ideal.

Continuity of care. This subtheme occurred 67 times, representing 5% of the meaning units coded as ROSC with 49% of the meaning units coming from treatment professionals (8/9 participants) and 51% coming from probation professionals (6/9 participants). Deacon, a therapist, made mention of the ways he and his coworkers do their best to keep treatment fluid for the clients:

We have a pretty good group of people, we have regular communication to kind of talk about what's going on even week to week. I think that can really help us as a if even if they can't have the same therapist (for both individual and group work) at least we're kind of communicating, so they're not having to retell all their story every single time they come in, every single detail.

Another example of continuity was described by Greg, an addiction-based case manager, as he talked about the flexibility of his job role, which also falls within the theme of integrated services:

I love the, also the flexibility of just being in different places and talking to different people and kinda connecting dots, because otherwise I think everybody kind of sits in their silo or can, and there's not enough communication back and forth and, and then triangulation's easy for clients if, y'know if therapist and probation officer aren't communicating it's real easy for the client to kinda use one against the other or just, um y'know, sort of manipulate the system a little bit and so I think it helps with that just knowing that we're all on the same team. And it helps the client feel more supported I think, to where they don't see, hopefully don't see the probation officers as 100% punitive and the therapist 100% pushover or whatever y'know, that there's some level of, um, balance between all that.

Partnership-consultant relationship. For this subtheme 83 meaning units emerged, representing 6% of the meaning units coded as ROSC data with meaning units from treatment professionals (9/9 participants) accounting for 47% and meaning units from probation professionals accounting (8/9 participants) for 53%. Jerrod, a therapist, talked about his approach in conversation with clients stating, "I'm here... I'm here to help, that sounds cliché, but I'm here

to be with you.” For probation officers, Cole talked about doing his best to build trust with the client knowing that not all clients have good experiences with probation officers:

"I'm just a big bad PO and I'm gonna tell you how to do things" and I've caught people doing that, I've seen officers do that, and it's like well no wonder they don't like us, clients, they don't wanna deal with us, so again... That's things I've seen, and so that's why it's so important to get that trust with your client right off the bat so you can hopefully work with them.

Strengths-based. This subtheme was present 42 times, representing 3% of the meaning units coded as ROSC with meaning units from treatment professionals (7/9 participants) accounting for 57% and meaning units from the probation professionals (6/9 participants) accounting for 43%. An example of practicing from a strengths-based position comes from Alison, a probation administrator, in her description of her agency's efforts: "Y'know, when we, when they do something good and we praise them, when we acknowledge they've done something good like they got a job, and we are super proud and we super acknowledge that, or they've been clean for 30 days." As a therapist, Deacon talked about how he has been frustrated before when clients relapse, but how he makes efforts to find the strength in the situation and build from that information:

For me that's why I think trying to pay attention to small amounts of progress they've made to see if there is other you know if it's, maybe it's not as simple as they did or didn't use, but they had a bigger length. Um, they're not using as much, they um, figured out part of this problem, but they you know still just working on it.

Culturally responsive. This subtheme was present 3 times, representing 0.2% of the meaning units coded as ROSC with meaning units from treatment professionals (2/9 participants)

accounting for 100% and no contribution from the probation professionals. An example comes from Claire, a therapist as she describes her efforts to tailor therapy to the client's source of support.

...but that's what I would love for it to be is just, bringing people in and y'know talking about, if you have a spiritual or a religious belief y'know like, how are you engaged in that and like how can we maybe even bring like, clergy member in and y'know talk about that with them and, having people from every area of your life understand more,

Responsive to personal beliefs. There were 9 total codes for this subtheme, representing 0.7% of the meaning units coded as ROSC with meaning units from treatment professionals (2/9 participants) accounting for 56% and meaning units from probation professionals (1/9 participants) accounting for 44%. As a probation administrator, Janice expressed a desire to include practices with a spiritual component saying, "Utilizing more of the spiritual things, not necessarily religion, but tying into those types of things." Elizabeth noted benefit from her efforts to build on personal beliefs in her work with clients in therapy:

And you know if they are spiritual people, and that's one thing that I really enjoy that is part of evaluations is we ask, do you have any spiritual affiliation, and that helps so much because you know it's not that something I push on every client, but if they have that and they're willing to um integrate that into their treatment plan, that is so amazing how that goes hand in hand with recovery, and it helps.

Commitment to peer recovery. For this ROSC subtheme 13 meaning units were identified, representing 0.9% of the meaning units coded as ROSC with 62% coming from treatment professionals (4/9 participants) and 38% coming from probation professionals (3/9

participants). As an example of this commitment, Emily, a treatment administrator, talked about her wish to use funds to offer peer support to clients at the agency:

Everybody would have a peer support worker. I think that would be very important for an individual to be placed with a person has had, a peer that has had a length of sobriety. I'm not talking about just somebody that's had a year of sobriety, but somebody that's had several years of sobriety. I think that's important. Paired with somebody that is; so, a current individual struggling with their sobriety paired with an individual that has had years of sobriety, kind of like AA/NA. But not the focus of the structure of AA.

In talking about her efforts to connect to peer recovery supports, Hazel, a probation administrator, stated, “The different interventions that we refer to, the different community based resources, if it's a therapist or even a peer mentor or a recovery coach, or whatever element that that individual is serving in that person's life.”

Inclusive of voices in recovery. Three meaning units were identified for this subtheme, representing 0.2% of the meaning units coded as ROSC in the data. Of those meaning units, 67% were from treatment professionals (1/9 participants) and 33% from the probation professionals (1/9 participants). As a therapist, Jolene reflected on the lack of voice many of her clients have and how she provides space for their voice:

I feel like a lot of times, and this is just my experience, I'm not saying every client that I see but the primary clients that I see in this setting, I don't know how much they feel like their wishes or their views or their perspectives have really been heard, acknowledged or respected and so when somebody comes in and even if it's so out in left field, something that, that's their perspective, and I have to really respect that and kinda work through that process with them instead of countering and challenging, no you're wrong and this isn't

right and you're a this and you need to do, you know I feel like that wouldn't change regardless of setting.

Similarly, Abby talks about the benefits of having child advocates in the community that can provide voice to the children on probation that are also involved in the foster care system:

That the client knows that person is about them, for them. Their voice. Not somebody who's gonna punish them or can throw them in jail, or maybe judge them or um, but just that strong positive influence and person they can talk to and person that's gonna be maybe stable person in their life.

Integrated services. For this ROSC subtheme, 103 meaning units were found, representing 7% of the meaning units coded as ROSC with 40% coming from treatment professionals (9/9 participants) and 60% from probation professionals (9/9 participants). A high level of integration is revealed in this example from Alison, a probation administrator:

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.

Further, Janice, a therapist, gave her take on this shared position and the resulting improvements to her collaboration with probation saying, "A beautiful thing is that we have our go between [...] that works for both places and that brings another element of resources so um, without that, it's really hard, but I feel like having that person that bridges the gap between [our agency] and like probation helps a lot."

Education and training. This subtheme occurred 29 times, representing 2% of the meaning units coded as ROSC with 52% of codes coming from treatment professionals (5/9 participants) and 48% from probation professionals (7/9 participants). An example of this is represented by Alison, a probation administrator regarding her probation officers when she states, “and so staff have been trained to work with the client and draw it out of them to set goals around their highest risks, and then supervisors measure, y'know did you at least hit one or two of their high risk goals in developing their supervision plan.” As a therapist, Claire discussed another piece to this theme, which is to provide system-wide education to the larger community. She described an idea they had at the agency to provide this stating, “We even had thought about doing a group where clients would bring family members to group with them to do some of that psychoeducation about addiction, how addiction impacts family systems.”

Ongoing monitoring and outreach. This ROSC subtheme occurred 34 times, representing 2.5% of the meaning units coded as ROSC with 35% coming from treatment professionals (6/9 participants) and 65% from probation professionals (8/9 participants). In his role as a probation officer, Cole demonstrated an example of this subtheme when he said, “...it'd be nice if you could have more staff to be able to do more things such as have surveillance officers to be able to go out and check up on clients late at night to make sure hey, are they doing the things they need to do?” Another probation professional, Roger, described outreach he offers clients:

I tell most of my folks, if they're leaving on decent terms, if you need something give me a call because I would much rather field a phone call or two, or have them come in and see me, and let's get something back on track before we're doing it all formally again. And sometimes I think just that offer of, if you need something give me a call, I say give me a call, I'm not going anywhere.

Outcomes-driven. This subtheme emerged six times, representing 0.4% of the meaning units coded as ROSC with all six meaning units coming from probation professionals (4/9 participants). Cole highlighted the spirit of outcomes-driven probation services:

Our boss, [Her name], really has--well when she took over 7, 8 years ago, whenever it was, maybe even more than that now I can't remember, probably more--that was really one thing she really kinda instilled in all of us is, let's not just go through the motions, let's be the best agency out there, let's just not kinda, well, this is what they say we have to do so that's all we need to do kind of a thing. I think we've all kinda jumped on board with that and we do, we compare ourselves to other agencies all the time, and you're like wow, look at this, we get the highest success rate, or we're the second highest in the state, oh our revocation rate is the lowest in the state of [state name], I think we're the second most, last year if I remember correctly, something like that.

Simply put, Hazel, a probation administrator, mentioned, "I track a lot of data. I love data because it doesn't make sense to me to continue to do things that haven't been proven to be effective."

Research informed. There were 26 meaning units for this subtheme, representing 2% of the meaning units coded as ROSC with 23% of meaning units coming from treatment professionals (2/9 participants) and 77% from probation professionals (5/9 participants). Alison, a probation administrator, gave a clear example of this subtheme stating, "Yeah, in 2008 the state agency actually kicked off, um, evidence based practices, based on the research..." As a therapist working with probation officers, Claire mentioned how much it seems the probation officers are well-informed and up to date with best practices:

And I think too like I think the POs that we have they're very educated, they're always going to trainings, so I think that they're, I mean I believe they're pretty well read about like what approaches work and don't work and I've had clients that talk to, or I've had POs that have talked to clients about mindfulness.

Adequately/flexibly financed. There were 26 meaning units for this subtheme, representing 2% of the meaning units coded as ROSC with 35% of meaning units coming from treatment professionals (5/9 participants) and 65% from probation professionals (9/9 participants). As a treatment administrator, Emily expressed her efforts in finding funding for additional services saying, “I am trying to push the case manager, I'm trying to ask management to give me BSW (Bachelor's in Social Work) interns to where they can provide case management for our SUD (Substance Use Disorder) clients, and we don't have to worry about billing.” Similarly, Alison expressed her efforts to keep available funding stating, “I'm working on our budgets right now and um. So I have done my darnedest over my tenure as director to not let funding get into our daily decision making of our client interactions, client dealings.”

Acute Care Subthemes

To best understand the nature of alignment toward the acute-care model, I will present the findings related to particular characteristics of this model.

Prompted by crisis. This subtheme emerged six times in the data representing two percent of the meaning units coded as acute-care. Treatment providers (1/9 participants) contributed 17% of the meaning units for this subtheme and probation professionals (4/9 participants) contributed 83%. As a complaint regarding some decisions made at the system level, Hazel, a probation administrator expressed concern regarding a lack of effort on the part of legislators to take into

account the impact their decisions make on families. She expresses how budget cuts have led to cuts in the state's prevention services, which leaves only enough money for crisis intervention:

They have a budget that they have to balance and there's only so much that goes around, and how can you save that? You have to make some of those difficult decisions. But do you understand that those decisions that you're making is not just about saving a dollar, you are negatively impacting somebody's entire life, because there's no more head start and there's no more parent's teacher's funding, that whole prevention piece. Research shows you can provide that from birth-5 they're likely not going to enter the system. But they've pulled a lot of funding because they've had to put it back into the facilities. We're not feeding the right end of the piece.

Brief treatment/intervention. This acute care subtheme was found 16 times in the data representing six percent of the meaning units coded as acute-care. Treatment professionals (7/9 participants) contributed 81% of the meaning units and probation professionals (3/9 participants) contributed 19%. This subtheme was often found as a result of the system in place, which can be understood through Emily's comment that, "all the powers that be aren't going to authorize outpatient treatment for a year." From the probation standpoint, Roger discussed how completing probation can sometimes be simply a matter of checking off boxes as he said, "Interesting question cause there's two levels to it, one, your times up and you've met all your stuff, all your criteria, so doing the paper drill it's like okay you've checked all your boxes, have done picked up paying your charges, you're good to go..."

Purpose of stabilization. There were 20 meaning units for this subtheme, which represents seven percent of the meaning units coded as acute care. Treatment professionals (5/9 participants) contributed 40% of these meaning units and probation professionals (6/9

participants) contributed 60%. An example of this from probation comes from Justin describing the role of probation officers as he states, “The role would be monitoring court ordered conditions of probation and holding offenders accountable.” One contributing factor to the time a person spends in treatment has to do with their medical necessity, which indicates this subtheme. Emily, a treatment administrator, made mention of this saying, “And then, medical necessity, that also drives the treatment if the client is medically needing inpatient but isn't wanting to go, then we have to drive it that way too.”

Singular focus on symptom suppression (sobriety). For this subtheme, 15 meaning units were found representing five percent of the meaning units coded as acute care with 27% of the meaning units for this subtheme coming from treatment professionals (2/9 participants) and 73% from probation professionals (5/9 participants). As a probation administrator, Hazel found that she has a different definition of successful probation compared to the larger system where the primary focus is on an absence of the “symptom”. She describes, “When we are tracking success, the way that the state defines success is a little bit different than the way we define success. When it comes to the different data, statistics that the state compiles, their idea of success is that an individual didn't end up in prison.” As a compromise, Janice, a therapist, noted that she sometimes has to focus on the “symptom” stating, “I've actually put it as a goal for the treatment plan as just, ‘I need to finish treatment as a requirement of my probation’.”

Professional-dominated decisions. This subtheme was the most frequent of all representing 27% of the meaning units coded as acute-care. Treatment professionals (9/9 participants) contributed 21% of the 76 total meaning units for this subtheme and probation professionals (9/9 participants) contributed 79%. An example of this subtheme within probation is demonstrated by this quote from Roger regarding a client, “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." A representative example within treatment is captured with Emily's statement as an administrator that, "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."

Short-term service relationship. This subtheme emerged from the data six times, representing two percent of the meaning units coded as acute care. Treatment professionals (5/9 participants) contributed 83% of the meaning units coded as and probation professionals (2/9 participants) contributed 17%. An example of this subtheme came from Greg, addiction-based case manager, as he described his relationship with the client's probation saying, "stability is probably the biggest thing. I mean, I don't expect to be there at, y'know at the end goal where they get to where they wanna be necessarily, cause a lot of that's gonna take, gonna be after probation's done and they're no longer seeing me." Within treatment, Claire, a therapist, discussed her experience of the service relationship timeline:

Expect? I would say probably an average of twelve weeks. It's kind of an expectation, I would personally hope to be working with them longer than that, but that seems kind of be the parameters we kind of give them it seems like. So I would say probably an average about twelve weeks.

Expectation of resolution to problem. There were 17 meaning units identified as reflecting this subtheme, making it 6% of the total meaning units coded as acute care. Treatment professionals (4/9 participants) contributed 29% and probation professionals (5/9 participants) contributed 71%. This subtheme was demonstrated by Roger, a probation officer, as he discussed a client case saying, "He's getting a recommendation to go serve 81 days in jail, that's what he

has left on his sentence, cause he doesn't get it and he should probably figure it out when he's 20 than before he's 30, or before he's 45.” Claire, a therapist, discussed how she’s seen this expectation manifest at the system level:

Cause a lot of times our clients are going to inpatient for twenty-one, twenty-eight days and then the inpatient place is like "okay, see ya!" And then they're basically like spit out back into this community that they've used in and learned their behaviors in and then we expect them to stay clean and. There needs to be something different with the way that we discharge clients from inpatient.

Uniform delivery of services. This subtheme was the second largest from the data representing 25% of the meaning units coded as acute care. Of the 70 total meaning units for this subtheme, 24% were from treatment professionals (8/9 participants) and 76% from probation professionals (8/9 participants). As a treatment administrator, Drew discussed his awareness of how some therapists have a uniform way of responding to clients saying, “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.” As a probation officer, Justin described the procedures he follows automatically when he receives a case related to substances:

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.

Re-entry interpreted as failure. This subtheme occurred 17 times in the data representing six percent of the meaning units coded as acute care. Treatment professionals (4/9 participants)

contributed 18% and probation professionals (7/9 participants) contributed 82%. An example from Greg, an addiction-based case manager, captures this subtheme in a non-treatment rural community context:

It's interesting, I go to [town name] once a week and it's interesting how their kind of helping agencies are different. It's a small town so they don't have much, but one of the places they do have is sort of connected to some of the churches I think and stuff but, they've decided that if a client, if any person's name is in the paper for a drug or alcohol related charge then they refuse to help them for a month, and that's kinda frustrating at times, because not every situation's the same and this place offers things like, um, similar to what Salvation Army would do, y'know clothing, food options, even some sort of emergency funds and that kind of thing and so. Often when I'm meeting a client for the first time, they've just gotten their charges or whatever, and so they're sort of on that list where they're refused some help initially, and I usually don't try to fight that head on too much cause it seems like a policy issue and so then we just try to look at other y'know avenues, other ways to try and connect them to help

Lack of research-informed care. This acute-care subtheme emerged 18 times representing six percent of the meaning units coded as acute care. Treatment professionals (5/9 participants) contributed 39% and probation professionals (3/9 participants) contributed 61%. Some instances of this subtheme came in the form of a complaint about the current system limitations such as when Claire, a therapist, talks about wanting greater access to training:

The lack of resources available to us as far as convenient education. That's a huge barrier. Because if you think about it we're always trying to do empirically based work, we're always trying to be on top of like the, not the newest and greatest but like, what's proven

to work well with clients and if we don't have access to that stuff, then what are we doing?

Other instances of this subtheme presented in the form of personal approaches taken by service providers and incongruence with the research-informed practice. This example is from Roger, a probation officer, talking about how he knows he is expected to use the “four to one rule” of motivational interviewing, but that it’s not always a fit for the process:

The four good things, you know generally, motivational, you've got four positive things for any critical thing you say. And then there are times you are screwing up bad enough, you're gonna get five bad things and one good thing. Hey, I'm glad you made it today, let's talk about all this other shit you got going on because we need to get into the weeds instead of dancing around, talking about how pretty the house is behind us, no no, we're in the weeds today, you're positive for three drugs, got arrested two days ago, didn't bother to tell me, and you got kicked out of your house. Alright, well, I'm glad you shared that with me, I'm glad you showed up today, that's all I got for two good things let's started talking about getting into it and start problem solving.

Few connections to non-treatment supports. This acute-care subtheme emerged eight times from the data representing three percent of the meaning units coded as acute care.

Treatment professionals (1/9 participants) contributed 25% and probation professionals (4/9 participants) contributed 75% . As a probation officer, Abby demonstrates an example of this as she talks about the connections she will make for her juvenile clients, but not necessarily for her adult clients:

So you still wanna consider the person in the environment and what's going on in their world, but it's more of a client self-report when it comes to an adult, whereas you have

more information and collateral information from y'know kid'll say "oh things are good" "how's school?" "good" "how's home" "good." Well I'm gonna talk to your mom and found out if it's good, I'm gonna talk to your principal and your teachers, find out if it's good. You don't do that as much with the adult client. You will talk to maybe their employer or their therapist or whatever too, but not on the same day to day level as you do with a juvenile.

From a treatment perspective, Michaela describes where her role as a therapist ends stating, "So, if there comes a point where the client is stuck, or doesn't want to move forward, then my investment ends there." She doesn't continue to discuss the options for the client outside of treatment when that doesn't work, which makes her statement indicative of this subtheme.

Lack of follow up. This subtheme emerged 12 times from the data representing four percent of the meaning units coded as acute care. Treatment professionals (3/9 participants) contributed 33% to this subtheme and probation professionals (4/9 participants) contributed 67%. Hazel, a probation administrator, described a limitation that keeps her and her staff from feeling confident that clients leaving their supervision will do well:

Because sometimes the limit of theirs or when their supervision termination date comes up, even though we let them off probation, or the court lets them off probation, doesn't necessarily mean that they're ready and they've got all the armor that they need to fight the rest of their lives that they have.

Themes from Research Question 2

With the second research question we gain a sense for what barriers exist in the current systems of care on both the individual and system level that would make transition to a ROSC model difficult. Of all meaning units coded as barriers, 47% emerged from the treatment sample

(200 meaning units) with 18% reflecting individual-level barriers for treatment providers and 82% reflecting system-level barriers. Of all meaning units coded as barriers, 53% emerged from the probation sample (229 meaning units) with 18.3% reflecting individual-level barriers for probation professionals and 81.6% reflecting system-level barriers.

Individual-level Barriers

Barriers at the individual-level weren't prevalent with either professional group, however, barriers at this level focused on the personal challenges such as keeping up with high demands on the job, having less experience in the job role, and recognizing human weaknesses. As an example of an individual-level barrier, Alison, a probation administrator, reflected on how she falls back into old ways of thinking when working directly with clients, which becomes more like the 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.

High workplace demands. This emerged as a main subtheme for treatment professionals with five out of nine participants mentioning this and a dominant subtheme for probation professionals with eight out of nine participants noting this. This subtheme captures the limitations on an individual's work when they must navigate multiple roles, feel pulled in many directions, or experience a heavy workload. These demands can build to a point where the professional's hands are tied; they desire to take more action related to recovery-oriented work, but other systems beg for their attention. An example can be found in Hazel's (probation

administrator) description of how the job demands can impact the probation officers she supervises:

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.

Another example can be found from Janice's personal experience on the job as a therapist stating, "Client load is huge. ...and the direct service hours is, for me overwhelming."

Early Development. This emerged as a main subtheme for both treatment (6/9) and probation (4/9) professionals. This subtheme describes the impact of development and experience with the job on the service provider's alignment toward acute-care versus ROSC. An example of this is seen from a description Deacon gives of 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.

The following example from Greg, an addiction-based case manager, 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 like, and I'm just more candid with them like, "do you need help with this or is this something you'd rather do on your own?" Y'know, whereas before I think I just, I would just say y'know "let's meet next week and we'll go do this together," and now it's "how do you wanna handle this?" y'know kind of thing and do you need help or not, that sort of approach.

Human factors. This subtheme emerged somewhat in the treatment sample (1/9) and was a main theme from probation professionals (5/9). Statements of this nature described the imperfection of human help and how slips from the more recovery-oriented, research-informed care were due to human factors such as taking something personally, acting out of frustration, and having biases. An example of this subtheme comes from Deacon's description of how he has let his own emotions or desires influence the work he does with clients, causing him to take more of an acute-care approach of dominating the decision making versus the ROSC approach of letting the client direct the process:

...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

Alison, a probation administrator, made note of this self of the helper phenomenon while reflecting on the probation officers she works with:

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. Another PO has a criminology, another is social work, another criminology, another criminology, another social work, family studies, no degree, education maybe. [...]. So I guess what I'm saying is, we probably, a majority of us went into this. 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.

System-level Barriers

Barriers at the system-level often emerged when service providers had complaints about limitations on their work due to policies, funding, community culture, or the nature of the profession. Professionals described frustration with the lack of feedback from other systems and gaps in services, which dampen the effectiveness of recovery-oriented practices. For example, Alison, a probation administrator, expresses the challenges clients face when moving between systems:

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...

Inadequate funding. Lack of funding emerged as a dominant theme with each professional noting this as a system-level barrier (18/18). Many mentioned the problems at the

state level that contribute to this barrier, and some discussed cuts that have been made to mental health and prevention efforts. Emily discussed how inadequate funds impact her decision making as a treatment administrator:

So that's--it's all funding, it's all money. We don't have the resources to do a day program, we don't have the resources to do peer support. You can do peer support through [funding source] if you want, but it drains your money so quickly that we could not provide the individual and group services that we do now.

Another treatment administrator, Drew, offered insightful comments about this funding issue in the smaller communities:

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.

In the probation setting, Roger discusses the inadequate access to funds when his agency manages a budget that only includes money for payroll as he states, “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.”

Mismatched goals/priorities. This system-level barrier emerged as a main theme for treatment professionals (4/9) and a dominant theme for probation professionals (8/9). Roger, a

probation officer, discussed his challenges in complying with the expectations placed on him when it turns into a checkbox:

And sometimes it becomes a paper drill of making sure we checked the right boxes and we kinda lose the whole point of, like effective practices in community supervision, EPICS is what we call them on our end, doing motivational interviewing, okay. There are times you don't get four good things for the one bad thing you've done if you're screwing up.

As an administrator of her probation agency, Hazel gives an example of the different views she has on what's best compared to the lawmakers:

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.

Untimely/Disjointed Services. This emerged as a main subtheme on the system-level for both treatment professionals (4/9) and probation professionals (7/9). This theme details the experience of professionals needing a service for their client, but having to wait or having lack of continuity between systems. An example of having to wait for a service came from Emily, a treatment administrator, describing the slow nature of getting a client into inpatient treatment:

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.

Similarly, Alison, a probation administrator, describes a gap between services that negatively impacts the client:

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 *Red tape*. This system-level factor emerged from the data as a main subtheme for both treatment professionals (4/9) and probation professionals (5/9). As a treatment administrator,

Drew shared his dislike for the current admissions process they have in place:

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.

As an administrator for probation, Justin detailed the bureaucratic element to his work and how timing of the steps taken on a person's case can impact their access to funded treatment in the end:

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.

Poor recovery environment. This system-level factor emerged as a main theme for both treatment (4/9) and probation (4/9) professionals. This subtheme consisted of comments related to the communities around the clients in recovery as well as the individual's support group. This system-level barrier was well described by Drew, a treatment administrator, as he highlighted some challenges of recovery in rural communities:

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.

Lack of education and training. This system-level barrier emerged as a main theme for treatment professionals (4/9) and somewhat of a them for probation professionals (1/9). Some of the instances of this subtheme reflected the need for communities to learn more about recovery. An example of this came from Elizabeth, a therapist, describing a misunderstanding of recovery from the client's support group. She said, "And a lot of times they're like why aren't they better?"

Why are they still you know they're still using.” From a probation administrator standpoint, Alison described what she sees as a need in her state:

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.

Themes from Research Question 3

With the third research question we gain a sense for what facilitators exist in the current systems of care that could promote a ROSC approach on both the individual and system level. Of all meaning units coded as facilitators, 41% emerged from the treatment sample (204 meaning units) with 50% reflecting individual-level facilitators for treatment professionals and 50% reflecting system-level facilitators. Of all meaning units coded as facilitators, 59% emerged from the probation sample (294 meaning units) with 41.5% reflecting individual-level facilitators for probation professionals and 58.5% reflecting system-level facilitators. An example of a facilitator at the individual level comes from Cole as he describes his passion for the work as a probation officer and the strong relationship he works to develop with clients as he says, “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.” At the system-level Elizabeth describes the importance of other professionals she can be on the same page with for an increase in continuity of care as she states, “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.”

Individual-level Facilitators

Autonomy. At an individual-level, autonomy emerged as a main theme for treatment professionals with five out of nine mentioning this subtheme and probation professionals with six out of nine mentioning this as a facilitator. Having autonomy allowed the professionals to do the work best matching with their individual values and beliefs to the best of their ability even within systems that are not as recovery-oriented. For example, Janice, a therapist, said, “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.” This freedom was also noted by Greg in his work as an addiction-based case manager:

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.

Desire for successful outcomes. This individual-level facilitator emerged as a main subtheme for both treatment (4/9) and probation (6/9) professionals. From an administrator’s standpoint, Emily described how she sees this desire in her staff saying, “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.” Emily’s example points to the capability of the treatment system to maintain a change as long as the individual professionals

are on board with it. Similarly, talking about his staff, Justin noted, “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.”

Job experience. This individual facilitator was a main subtheme for the treatment professionals (4/9), and noted by some of the probation professionals (3/9). As a therapist, Jolene reflected on her experience over time and how this has shaped her work toward the more recovery-oriented approach of being person-centered:

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.

Emily, a treatment administrator, also reflected on her changes as a therapist over time toward a more recovery-oriented approach that understands the continuum of health and wellness for someone in recovery:

You think that you can, I guess, cure it all, for lack of a better word. And that a client will come into treatment and everything will be all better, and they'll never be back. And then, as you become a seasoned therapist, you're like, no, I expect them to come back. They will be back. If they're not back, it's not because things have gotten all better, it's because maybe they're ignoring something. I think that that has changed for me.

As a probation administrator, Alison noted her confidence in staff to make appropriate recommendations due to their experience saying, “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.”

System-level Facilitators

Professional collaboration. This system-level facilitator emerged as a dominant subtheme with every single participant (18/18) mentioning this. Professional collaboration ranged from co-worker to co-worker to working with another agency to write grants. This facilitator is essential for building integrated service systems and seems to be widely accepted as a helpful practice among these service providers. From her perspective as a probation administrator, Alison noted the benefits of collaboration, especially stemming from the shared position her agency has with the community mental health center:

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?

Drew, a treatment administrator, talked about the importance of agency administrators taking the lead in collaboration efforts and change overall:

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.

Supportive workplace environment. This system level facilitator emerged for some of the treatment professionals (3/9) and was a main theme for probation professionals (6/9). In her probation agency, Alison noted the support the staff receive from one another stating, "So they're continuously staffing things over the cubicles. I mean, so they get so much peer coaching, if you will." Cole, a probation officer, highlighted the benefits of having the support of co-workers:

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.

Creative/Grant funding. This system level facilitator emerged for some of the treatment professionals (3/9) and was a main theme for the probation professionals (5/9). This facilitator helps promote integrated services as well as flexible/adequate funding for services. Greg, an addiction-based case manager, highlighted the work done between the probation and treatment agencies in the community to find funding:

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.

As a probation administrator Alison noted the help of grant funding even during financial losses:

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.

Table 4: Participant Demographics

Demographic Information of Participants (Total N=18; Treatment N=9; Probation N =9)

Variables	Treatment Professionals		Probation Professionals	
Average Age (Years)	37 (Range: 28-49)		43 (Range: 38-52)	
Average Years in Profession	6 (Range: 1.5- 13)		20 (Range: 16-26)	
Average Years in Role	3 (Range: .5-8)		12 (Range: 3-17)	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
Sex				
Male	3	33%	4	44%
Female	6	67%	5	56%
Job Role				
Diversion Officer	-	-	1	11%
Probation Officer	-	-	3	33%
Parole Officer	-	-	1	11%
Administrator	2	22%	3	33%

Therapist	7	78%	-	-
Case Manager	-	-	1	11%
Education Background				
Bachelor's Degree	0	0%	5	56%
Master's Degree	9	100%	4	44%
Clinical Training Background				
Social Work	4	44%	1	11%
Addictions	9	100%	0	0%
Marriage/Family	3	33%	1	11%
Counseling	2	22%	0	0%
Race/Ethnicity				
African American	1	11%	0	0%
Mexican/Hispanic	1	11%	0	0%
White/Hispanic	1	11%	0	0%
White/Non-Hispanic	6	67%	9	100%

Table 5.1: Qualitative Results

Research Question 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 (ROSC) model?

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

R1 Results:

Alignment

Treatment Professionals -----9/9 interviews described greater alignment with ROSC

Probation Professionals -----8/9 interviews described greater alignment with ROSC

Source

ROSC Codes at Individual-level (77% of ROSC codes)

Treatment Sample: 55%

Probation Sample: 45%

ROSC Codes at System-level (23% of ROSC codes)

Treatment Sample: 34%

Probation Sample: 66%

Acute-Care Codes at Individual-level (52% of Acute-care codes)

Treatment Sample: 22%

Probation Sample: 78%

Acute-Care Codes at System-level (48% of Acute-care codes)

Treatment Sample: 37%

Probation Sample: 63%

ROSC Principles:	Tx%	PO%	M Units	%Total	Tx N	PO N
<i>Many pathways</i>	79	21	28	2	8/9	3/9
<i>Self-directed/Empowering</i>	62	38	140	10	9/9	8/9
<i>Recognition of need change</i>	52.5	47.5	40	3	8/8	8/8
<i>Holistic</i>	47	53	116	8	9/9	9/9
<i>Cultural dimensions</i>	80	20	5	.4	2/9	1/9
<i>Continuum improved health</i>	50	50	82	6	9/9	9/9
<i>Emerges from hope</i>	40	60	15	1	4/9	6/9
<i>Healing and Self-redefinition</i>	65	35	20	1.4	5/9	5/9
<i>Transcending shame stigma</i>	95	5	19	1.4	6/9	1/9
<i>Supported by peers and allies</i>	75	25	12	.9	9/9	2/9
<i>Re-joining life in community</i>	22	78	27	2	5/9	5/9
<i>Recovery is a reality</i>	33	67	3	.2	1/9	2/9
Totals for ROSC Principles:	56	44	507	37	9/9	9/9
ROSC Elements:	Tx%	PO%	M Units	%Total	Tx N	PO N
<i>Person-centered</i>	57	43	196	14	9/9	9/9
<i>Inclusive of family and allies</i>	82	18	49	4	8/9	4/9
<i>Individualized/comprehensive</i>	53	47	118	9	9/9	9/9
<i>Anchored in the community</i>	39	61	67	5	8/9	8/9
<i>Continuity of care</i>	49	51	67	5	8/9	6/9

<i>Partnership-consultant</i>	47	53	83	6	9/9	8/9
<i>Strength based</i>	57	43	42	3	7/9	6/9
<i>Culturally responsive</i>	100	0	3	.2	2/9	0/9
<i>Responsive to beliefs</i>	56	44	9	.7	2/9	1/9
<i>Commitment to peer recovery</i>	62	38	13	.9	4/9	3/9
<i>Inclusive of voices of recovery</i>	67	33	3	.2	1/9	1/9
<i>Integrated services</i>	40	60	103	7	9/9	9/9
<i>Education and training</i>	52	48	29	2	5/9	7/9
<i>Ongoing monitoring outreach</i>	35	65	34	2.5	6/9	8/9
<i>Outcomes-driven</i>	0	100	6	.4	0/9	4/9
<i>Research based</i>	23	77	26	2	2/9	5/9
<i>Adequately/flexibly financed</i>	35	65	26	2	5/9	9/9
Totals for ROSC Elements:	50	50	874	63	9/9	9/9
ROSC Model Codes	Treatment%		Probation%		TOTAL	%Model Codes
Totals:	52		48		1,381	83
<u>Acute Care Subthemes:</u>	Tx%	PO%	M Units	%Total	Tx N	PO N
<i>Prompted by crisis</i>	17	83	6	2	1/9	4/9
<i>Brief treatment/intervention</i>	81	19	16	6	7/9	3/9
<i>Purpose of stabilization</i>	40	60	20	7	5/9	6/9
<i>Singular focus on sobriety</i>	27	73	15	5	2/9	5/9
<i>Professional-dominated</i>	21	79	76	27	9/9	9/9
<i>Short-term relationship</i>	83	17	6	2	5/9	2/9
<i>Expectation of resolution</i>	29	71	17	6	4/9	5/9
<i>Uniform delivery of services</i>	24	76	70	25	8/9	8/9
<i>Re-entry interpreted as failure</i>	18	82	17	6	4/9	7/9
<i>Lack of research-informed</i>	39	61	18	6	5/9	3/9
<i>Few connections</i>	25	75	8	3	1/9	4/9
<i>Lacking follow up</i>	33	67	12	4	3/9	4/9

<i>Acute Care Model Codes</i>	Treatment%	Probation%	TOTAL	% Model Codes
<i>Totals:</i>	30	70	281	17

Note: (Tx = Treatment; PO = Probation; M Units = Meaning Units)

Table 5.2 1: Qualitative 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?

- a. What are the professional beliefs and organizational values that act as barriers to implementing the ROSC model in an addiction treatment community?
-

R2 Results:

Barriers

<u>Individual-level</u>	<u>Total Count</u>
Treatment Sample: 18%	36
Probation Sample: 18%	42
<u>System-level</u>	<u>Total Count</u>
Treatment Sample: 82%	164
Probation Sample: 82%	187

Barrier Subthemes:

Individual-Level:

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

System-Level:

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

Table 5.2 2: Qualitative 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?

R3 Results:

Facilitators

<u>Individual-level</u>	<u>Total Count</u>
Treatment Sample: 50%	102
Probation Sample: 41.5%	122
<u>System-level</u>	<u>Total Count</u>
Treatment Sample: 50%	102
Probation Sample: 58.5%	172

Facilitator Subthemes:

Individual-level:

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

System-level:

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

Conclusion

Results from research question one regarding model alignment demonstrate that the ROSC model was a dominant theme with 9/9 treatment professionals and 8/9 probation professionals speaking to this model more than the acute-care model in their ideas and practices described. It was discovered from research question two that system-level barriers were more prevalent than individual-level barriers to transitioning to the ROSC model for both treatment and probation professionals. For the treatment professionals in my sample, the individual-level facilitators found as a result of research question three were evenly split with the system-level facilitators found. For probation professionals, however, the system-level facilitators were more prevalent than the individual-level facilitators for transitioning to a ROSC model.

Chapter 5 - Discussion

Introduction

As the ROSC model expands to communities around the nation, it is key to understand the barriers and facilitators that systems may face in making a change from the acute-care model. This study provides important information for communities to best plan for implementation, whether it be overcoming existing barriers or finding ways to maximize facilitators in place. Although this study cannot be generalized to all communities, the results give insight to the individual and system-level barriers from treatment and probation perspectives that would need to be resolved to move toward a ROSC model. The findings related to facilitators are also compelling as they shed light on what's possible from individual efforts when the larger systems are rigid or limited in some way.

Discussion of Research Question 1 Findings

The first research question investigates the degree to which treatment and probation systems of care align with an acute-care or recovery-oriented systems of care (ROSC) model at both the level of the individual service provider and the system-level. Broadly, almost all participants in the sample (17/18 people) described more alignment with the ROSC model than with the acute-care model. Of all the meaning units for model alignment, 83% were coded as the ROSC model and 17% coded as acute-care. This result is a promising backdrop for the transition to a ROSC model. Not only do professionals in this sample have attitudes and beliefs that align with ROSC (e.g., focus should be on the individual, importance of involving allies), but some of the current practices in their systems also align with the model (e.g., grant funded treatment, integrated services). Interestingly, meaning units coded as "individual-level" contributed most to the meaning units coded as both ROSC (77%) and the acute-care model (52%). This reveals that

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. Probation professionals in this sample dominated the meaning units representing model alignment at the system-level for both acute-care (63%) and ROSC (66%) models in comparison to treatment professionals. This points to the uniquely important role of the systems in place in a probation context to implement and maintain change.

Additionally, probation professionals in this sample contributed most to the individual-level, acute care meaning units in comparison to treatment professionals, which provides clarity that interventions such as transforming to a ROSC model would be important to implement strongly at the probation system level to shape and support individual professionals in that change.

Overall, these findings help clarify the essential role of the individual professional in establishing and maintaining the ROSC model and the unique influence the probation system has in driving services.

Model Alignment

Of the meaning units coded as ROSC, 52% were from treatment professionals and 48% from probation professionals, which is promising considering the distinctly different roles these professionals have in working with clients. I expected treatment professionals in my sample to align most with the ROSC model based on the assumption that most therapists are trained in putting the client first and helping a client navigate change. It was surprising to see that most probation professionals also take on this role. Although probation officers are in the business of supervising individuals' compliance with a court order, many also considered themselves change agents and a vital support for their clients' chances at connecting back with the community in a lasting way.

Of the meaning units coded as acute-care, 30% came from treatment professionals and 70% from probation professionals. This stands out as evidence worth paying attention to for areas of need in these systems of care when considering a transition to ROSC. Although the percent of total meaning units coded as acute care in the data was small, the acute care codes that occurred were primarily from probation professionals. Probation officers have significant roles in the current system of care such that they do a certain amount of mediation between the judge and client. For example, each probation officer commented on having at least partial loyalty to the client under supervision as well as an obligation to uphold court orders. This unique position has a certain degree of flexibility, but exists within a wider network of systems that place rigid boundaries on the work (e.g., state and federal laws, uniform procedures, judges acting independently). Because of this, individual probation officers might lean on the side of law enforcement and loyalty to the court or case management and advocacy for the client (Labrecque, et al., 2013). This split position was acknowledged by a probation administrator, Justin as he reflected on the approaches taken by his staff:

An old interview question we used to use was, 'probation work can be both social work and/or law enforcement depending upon the situation or the person that you deal with, so on a scale of 1-10 with social work being 1 or 0 and 10 being pure law enforcement, where do you place yourself on the scale and why.' So typically, and dependent upon my personal, you know the supervisor's personal philosophy and the philosophy of the court and whatever and it [is], I'd say most of the people I know I would say that they would probably want to hear the typical answer would be "well I'd say I'm about a 6 or a 7" however, knowing that you need to work that scale, you know, in this particular situation, maybe I'd be a 1, but then in this particular situation I'd be a 9 or a 10...

Individual-level Influence

Investigation of model alignment included a consideration for individual and system-level contributing factors. Of all the meaning units coded as ROSC, 77% were associated with individual-level factors. Treatment professionals in my sample contributed 55% of the individual-level ROSC codes while probation professionals contributed 45%. These findings are encouraging as they suggest agreement with the ROSC model from the individual professionals executing the work with clients. Thus, the practices, values, ideas, and beliefs of individuals in this treatment community are primed for a transition to the ROSC model. The degree of similarity between treatment and probation professionals is encouraging as well since these two professionals often have mutual clients and need one another to do their best work (Lehman, et al., 2009).

Of all the meaning units coded as acute-care, 52% were associated with individual-level factors. With over half of the codes representing individual-level factors, again power can be placed on the individual professional to influence the work done with clients. Treatment professionals contributed 22% of the meaning units coded as individual-level, acute-care alignment while probation professionals contributed 78%. This result is telling of the differing professional perspectives taken by therapists and probation officers. A few probation professionals acknowledged that they were initially trained to be punitive with clients (“offenders”) and that the focus was on telling people how much they did wrong and how little they were following the court order, which is in opposition to the strengths-based nature of ROSC. There is a degree of self-selection into professions and it seems some individual probation professionals in this sample continue to hold onto certain aspects of the old training whether or not they realize (e.g., decision making dominated by the professional). With 22% of

the meaning units coded as individual-level, acute-care alignment coming from treatment professionals it's unclear what might inform this, however, the degree of variety between training programs of the individual therapists as well as the differing levels of experience on the job may contribute to this finding.

System-level Influence

Of all meaning units coded as “recovery-oriented”, 23% were associated with system-level factors. Although it is positive to have individual professionals with views predominantly aligned with the ROSC model, it is troubling that the system-level factors did not contribute more to the ROSC meaning units. Treatment professionals in this sample contributed 34% of the meaning units coded as system-level factors and probation professionals contributed 66%. It is important to consider how these two systems are different in purpose. The probation professionals are a subset of law enforcement answering to court orders while treatment professionals are only answering to the ethics of their practice, which are client-centered in the first place. It seems fitting that probation professionals in this sample talked more about the larger system since they have more direct contact with the system and more often experience the direct effects of its limitations on their work.

Although treatment professionals contributed more to the meaning units coded as individual-level, ROSC alignment, their perceptions of the larger systems of care contributed to the ROSC codes less in comparison to probation professionals. It seems treatment professionals in this sample are moving toward ROSC ideals, but their perceptions are that the systems in place governing treatment are slow to catch up. This came in the form of complaints treatment professionals had of limitations on services they could provide clients based on lack of funding, insurance restrictions, and other structural issues. The perceived contribution that system-level

factors make toward ROSC alignment for probation professionals in this sample is redeeming, however, and points to the potential of a shift, such as turning to a ROSC model, to effectively move through the system.

Of the meaning units coded as acute-care, 48% were associated at the system-level. It seems that a shift has occurred in the probation systems of care such that more focus is placed on developing effective practices in corrections work (Labrecque, et al., 2013), which could in turn be decreasing practices aligned with acute-care. Treatment professionals contributed 37% of the meaning units coded as system-level while probation professionals contributed 63%. Thus, probation professionals had more system-level codes than treatment professionals for both ROSC and acute-care. This result may be due to probation professionals having to work within less flexible bounds compared to treatment professionals. Where treatment professionals have quite a bit of autonomy in their day to day work and have fewer systems to answer to, probation professionals have more rules and guidelines to follow, more systems to answer to, and are ultimately bound to their role in law enforcement. Despite these differences, both systems of care have lingering acute-care characteristics, that would need to be addressed for successful transition to a ROSC model.

ROSC Subthemes

Of the subthemes that characterize the ROSC model, the most often occurring were person-centered (196 meaning units; 14%), self-directed/empowering (140 meaning units; 10%), individualized (118 meaning units; 9%), holistic (116 meaning units; 8%), and integrated (103 meaning units 7%). Services that are individualized and integrated have some of the most extensive research support for effective practices thus far in the addictions field (Sheedy & Whitter, 2013). Participants in this study spoke to the importance of collaborating with other

professionals to inform work with their clients. Particularly, one probation agency shares a position with the community mental health center, and multiple interviewees mentioned the benefits of this shared position. The position is grant funded so both agencies share that funding, which speaks to the potential that agencies have for creating recovery-oriented environments even when the larger systems have minimal funds or outdated policies. This possibility is also expressed by (White, 2008) in that government funding shouldn't be a limitation to making a transition to the ROSC model, but rather funding should be effectively gathered elsewhere.

The least often occurring were responsive to personal belief systems (9 meaning units; .7%), outcomes-driven (6 meaning units; .4%), cultural dimensions (5 meaning units; .4%), recovery is reality (3 meaning units; .2%), and inclusive of voices of those in recovery (3 meaning units; .2%). Each subtheme had representation from both treatment and probation professionals except for the outcomes-driven element, which did not emerge from the treatment sample, and the culturally responsive element, which did not emerge from the probation sample. The principle that recovery is a reality and the element of responsiveness to personal belief systems are both extensively supported in the research (Sheedy & Whitter, 2013), but unfortunately didn't represent many of the meaning units coded as ROSC in the data. It is possible that treatment professionals did not make mention of content related to recovery being a reality due to their shared role with me and the assumption that as therapists they are in the profession because they think change is possible. This assumption could have also played a part in probation professionals not often mentioning this subtheme. Further, multiple probation professionals acknowledged that it was easier for them to recall failures of people on probation often stating that "they just stand out". Since relapse is common in a process of behavior change, and recovery involves maintaining change long-term, it's likely that both treatment and

probation professionals have witnessed several people drop out of services or cycle back after successfully completing them. Over time, being witness to these challenges could wear on professionals without intentional efforts to notice the strengths in recovery or remember successful cases. This may inform a lack of the “recovery is reality” subtheme in the data.

“Responsiveness to personal belief systems” may have not emerged as much since it is specific and related to broader themes such as person-centered. There are other possibilities, however, and it’s interesting to note that related subthemes of “cultural dimensions” and “inclusive of voices in recovery” were also poorly represented in the data. This result opens an area of inquiry that needs to be explored since individual professionals and the systems of care they operate under may be limited in the degree to which they are person-centered. Although multiple treatment professionals mentioned themes of partnership and being person-centered, only a few specifically noted measures they take to engage the client with the client’s own belief systems (e.g., inviting clergy, discussing the meanings clients have for recovery-related phrases). For probation professionals in this sample, it was not clear whether cultural considerations or responsiveness to personal belief systems had any part in their evidence-based practices since this was a minimal subtheme in the data. It seems these professional systems could be missing the necessary education and/or training reminders to build this type of practice. Since treatment and probation professionals are in frequent contact with vulnerable clientele it is essential that efforts are made to lessen the degree of power imbalance, and one way to do this is to allow the client to be the expert on their life including a focus on their values, personal belief systems, and life experiences.

Compared to the probation professionals in this sample, treatment professionals contributed substantially to the meaning units coded as the recovery-oriented subthemes of

transcending shame and stigma (95%; 6/9 treatment professionals), inclusive of family and allies (82%; 8/9 treatment professionals), cultural dimensions (80%; 2/9 treatment professionals), many pathways (79%; 8/9 treatment professionals), supported by peers and allies (75%; 9/9 treatment professionals), inclusive of voices in recovery (67%; 1/9 treatment professionals), and healing and self-redefinition (65%; 5/9 treatment professionals). This may be due in part to the differences in training backgrounds between the two professional groups and the treatment-focused nature of this research study. Probation professionals contributed substantially to the meaning units coded as the ROSC subthemes of outcomes-driven (100%; 4/9 probation professionals), (re)joining/(re)building life in community (78%; 5/9 probation professionals), research-informed (77%; 5/9 probation professionals), recovery is a reality (67%; 2/9 probation professionals), ongoing monitoring and outreach (65%; 8/9 probation professionals), and adequately/flexibly financed (65%; 9/9 probation professionals). It is possible that probation professionals dominated some of these themes based on a systemic shift toward research-informed and data driven probation practices, at least those specifically under the corrections service systems (e.g., community corrections and parole) (Labrecque, et al., 2013). Many probation professionals in this sample would mention specific trainings they attended or practices they are expected to do in order to maintain evidenced based practices.

Acute Care Subthemes

Of the subthemes that characterize the acute-care model, the most often occurring were *professional-dominated decision making* (76 meaning units; 27%) and *uniform delivery of services* (70 meaning units; 25%). Participants would often mention the impact of court-mandated services on their practices. For example, therapists would note that they usually hope for clients to stay in treatment longer, but that often if the client “checks their boxes” they are

deemed “successful”, free to leave and often do instead of continuing the work. Probation professionals discussed their limited power in client outcomes when a judge has the final say. Some probation professionals talked about having a specific set of expectations for clients without much variability between clients, while some treatment professionals discussed making plans with clients that would vary based on their need and that often had much more to do with what the client defined as “success”. There are barriers on both the individual level and system level that would have to be removed to alleviate these strong acute-care characteristics.

Increased coordination between systems may be helpful in breaking down these acute-care barriers. One probation professional discussed his positive experiences with a judge who took time to consult on each case with the key players in the client’s life including both probation officers and treatment providers so that the judge could have a clear understanding of the person’s needs from multiple perspectives. In this case, collaboration minimized the gaps between judge and probation officer and even therapist, which seemed to benefit the client per this account. To further minimize these gaps, it is suggested that all parts of the system including the clients themselves be directly involved in the process of changing to and maintaining a ROSC model (Achara-Abrahams et al., 2010). Additionally, an important part of this process would be changing the attitudes of the service providers when the attitudes conflict with key ROSC principles and elements (Achara-Abrahams et al., 2010).

The least often occurring acute-care model characteristics were *few connections to non-treatment supports* (8 meaning units; 3%), *prompted by crisis* (6 meaning units; 2%), and *short-term service relationship* (6 meaning units; 2%). Each subtheme of the acute model was represented in both the treatment and probation professional sample. The probation sample contributed more to meaning units representing certain acute-care model characteristics than the

treatment sample, however. This is likely due to the unique role probation officers have to hold people accountable to the law, which suggests some natural rigidity in available practices. Probation professionals contributed substantially to the meaning units coded as the acute-care subthemes of *prompted by crisis* (83%; 4/9 probation professionals), *re-entry interpreted as failure* (82%; 7/9 probation professionals), *professional-dominated decision-making* (79%; 9/9 probation professionals), *uniform delivery of services* (76%; 8/9 probation professionals), *few connections to non-treatment supports* (75%; 4/9 probation professionals), *singular focus on symptom-suppression (sobriety)* (73%; 5/9 probation professionals), *expectation of resolution to the problem* (71%; 5/9 probation professionals), and *lacking post-intervention follow up* (67%; 4/9 probation professionals). Treatment professionals contributed substantially to the meaning units coded as the acute-care subthemes of *brief treatment/intervention* (81%; 7/9 treatment professionals) and *short-term service relationship* (83%; 5/9 treatment professionals). Although there is some rigidity in the probation system of care, there is a recognition of the time it takes to develop lasting change and the influence monitoring and outreach can have on an individual's likelihood of changing. The unique factor in probation services is that they are mandated, which increases the chances of client engagement (Farabee, Prendergast, and Anglin 1998; Polcin & Greenfield, 2003; Zhang, Roberts, and Callanan 2006). Treatment services for mandated clients are not often matching the length of probation usually due to a delay in sentencing or lack of available funds to begin treatment, and services are often cut short when probation ends.

Discussion of Research Question 2

Existing barriers at both the individual level of the service provider and the system level surrounding the service provider emerged from the data and provide insight into what would make a transition to the ROSC model difficult. Of all meaning units coded as barriers, 47%

emerged from the treatment sample and 53% from the probation sample. Of the meaning units coded as barriers from interviews with treatment professionals, 18% were at the individual level and 82% at the system level. Similarly, of the meaning units coded as barriers from interviews with probation professionals, 18.3% were at the individual level and 81.6% at the system level. 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. In the discussion of individual and system level barriers, dominant themes were defined as eight to nine interviews mentioning the theme while main themes were defined as four to seven interviews mentioning the theme. Three or fewer interviews mentioning the theme qualified as “some” professionals in the description of the results.

Individual-level Barriers

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. From the individual barriers emerged three subthemes that were either dominant or main themes in all cases except one: *high workplace demands* (treatment: 5/9; probation: 8/9), *early development* (treatment: 6/9; probation: 4/9), and *human factors* (treatment: 1/9; probation: 5/9).

The subtheme of *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). Participants discussed this barrier in the context of wanting to do more, but feeling strapped for time and money, or lacking the permission to do so based on policy. One

therapist talked about how she chooses to take more time out of her daily life to meet the needs of her clients. She described having to work under a policy where she has demanding “direct service” expectations where she must be spending most of her time providing services that are billable. This frustration was shared by other therapists. Even more probation professionals expressed this challenge as this presented as a dominant theme for them. 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. This ultimately puts limits on their ability to be anchored in the community as the ROSC model would suggest.

Early development (treatment: 6/9; probation: 4/9) is a fascinating individual barrier to the ROSC model implementation in that it seems to eventually expire within individual professionals upon having more experience on the job. In four of the interviews with treatment professionals, this subtheme came up in the context of speaking to how they view addiction, recovery, and effective treatment much differently as experienced therapists than they did early on. The differences discussed were most often reflecting a change in perspective from more acute-care characteristics (e.g., expectation of resolution to the problem; sole focus on sobriety) to more recovery-oriented ideas (e.g., letting the client self-direct the process, seeing recovery as a continuum of health). The other two therapists that spoke to this subtheme were early in their development as substance use therapists and would mention not knowing enough or having enough experience to fully answer some of the questions. One therapist in particular found himself changing his mind mid-way through responses to reflect an opposing or at least separate idea. Probation professionals addressed this subtheme in the context of their initial training as

early professionals and how the goals in training probation officers prior to 2008 were heavily focused on being punitive, which was a limitation to recovery-oriented practices.

Historically, addiction counselors have not received formal training in evidenced-based practices (Weissman et al., 2006), and most training in these practices ultimately happens on the job (Kerwin, Walker-Smith, Kirby, 2006). Thus, it is challenging to implement research-based practices without the training. As such, therapists might be left to figure out a personal model of therapy. In the case of participants in this study, most were dual licensed therapists that received formal training in another field and supplemented their mental health practice license with an addictions counseling license. Some of the therapists hold temporary addictions counseling licenses which require only payment (when the therapist is licensed in mental health) and commitment to take the addictions counseling test. This being said, substance use therapists early in their work will not have the same preparation and insight as experienced therapists. Unfortunately, therapists left to use a “self-study” approach or attending workshops to learn evidenced-based practices have not been found to experience a change in behavior within their practice, rather simply a change in knowledge (Olmstead et al., 2012). This limitation speaks to the need for direct supervision and follow up in addition to trainings in evidenced-based practices.

Human factors (treatment: 1/9; probation: 5/9) emerged as individual-level barriers for many probation professionals, but only somewhat for treatment professionals. Some probation professionals addressed this subtheme by mentioning how easy it can be for them to slip back into their old ways of supervising clients as this was the way they were trained to behave early on. They mentioned the “human factor” of getting frustrated with clients and wanting to react by putting them in jail. The treatment professional that spoke to this barrier described how he

sometimes has an emotional reaction to the client's behaviors and has to be careful to not take it personally and shift focus away from the client's needs. It was interesting that not more treatment professionals spoke to this issue as countertransference and boundaries are often topics of training in the mental health fields. It's possible that a lack of feedback on direct client interaction (via video or audio recording) lessens the attention given to these factors, or that this is a vulnerable topic to bring up in an interview. These factors are important to consider in a ROSC transition, however, as they can challenge an individual professional in maintaining evidenced-based practices, especially without direct supervision.

System-level Barriers

System-level barriers dominated the barriers mentioned for both professional groups. Six subthemes emerged that were either dominant or main themes in all cases except one: *inadequate funding* (treatment: 9/9; probation: 9/9), *mismatched goals/priorities* (treatment: 4/9; probation: 8/9), *untimely/disjointed services* (treatment: 4/9; probation: 7/9), *red tape* (treatment: 4/9 probation: 5/9), *poor recovery environment* (treatment: 4/9; probation: 4/9), and *lack of education/training* (treatment: 4/9; probation: 1/9).

Inadequate funding (treatment: 9/9; probation: 9/9) was a dominant theme for both professional groups. Treatment and probation professionals most often described funding as a barrier before mentioning any other barrier. 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. One probation professional, however, mentioned how no one at the state level governing their agency wanted to manage a grant. A

treatment professional talked about interest in larger grant funds, but that many larger grants are given to larger cities instead of small communities. 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.

Mismatched goals/priorities (treatment: 4/9; probation: 8/9) emerged in the data as a system-level barrier involving multiple subsystems. A couple treatment professionals and a probation professional mentioned differences in their goals for and views of clients and the views held by other service systems in small communities. The mismatch was that the small community service had placed rigid rules on who could receive the services based on if a person's charge or arrest was in the newspaper. Another mismatch presented by probation professionals involved the judge. The main complaint was that although probation officers spend so much time with the client on the case and have recommendations based in context, when presented in front of a judge, the judge often has no idea of all the efforts made and acts independently in ways that can undermine efforts made by the probation officers. Finally, both treatment and probation professionals spoke to the challenges involved in disagreements with one another on what's best for the client. Most often professionals said this could be resolved by providing one another information and collaborating on the best course of action. These results provide more evidence of the need for integrated services and all moving parts within communities to be on board with a recovery-oriented model for it to be implemented successfully.

Untimely/disjointed services (treatment: 4/9; probation: 7/9) emerged as a clear systemic barrier to implementing ROSC model elements. Treatment and probation officers both expressed frustration with the gaps that occur between inpatient treatment and the client's transition back to

outpatient treatment, medication services, and community living. Most discussed this as stemming from a lack of communication from inpatient services when clients are discharged thus making collaboration/integration an essential piece to overcoming this barrier. Professionals expressed particular problems with getting clients to services in a timely manner. For example, multiple professionals discussed the wait time for inpatient treatment being up to two months at times unless the client has insurance. This lacking resource is troubling since inpatient treatment is often recommended when the client is in a dangerous and serious pattern of substance use that is many times critical to address, especially if the client cannot maintain going to outpatient treatment services. Another untimely service can be the wait it takes for clients to receive medication services. This seems to be another bloated service system that cannot manage the demand in a timely way. Professionals expressed typically having to wait one-two months for clients to get into this service. These wait times may be fueled by a lack of staff and available funding.

Red tape (treatment: 4/9 probation: 5/9) was another system-level barrier that specifically seemed to limit professionals' efforts toward involving family and allies, bringing continuity to the care, and services being anchored in the community. Treatment professionals spoke to the challenges of involving family and allies when clients either choose not to sign releases or releases aren't signed early enough in the process to address serious concerns regarding the client in a timely manner. Therapists acknowledged the importance of client confidentiality and maintaining ethics, however, they noticed how this can limit access to the client's support system as well as place limitations on the location that therapists can do their work. Multiple treatment professionals expressed a desire to go to the client on certain occasions where the client was unable to come to them, or for the purpose of lessening the power imbalance between therapist

and client. A treatment administrator acknowledged the red tape involved with the admissions process for a client to access therapy and how it likely deters clients from returning to therapy because the closing process appears so final and rigid and the admissions process would be repetitive. Probation professionals made note of the hoops that a client has to jump through to even start treatment or qualify for the resources they need to comply with court orders. The red tape in these systems seems to have the worst impact on the clients themselves.

Having a *poor recovery environment* (treatment: 4/9; probation: 4/9) was a system-level barrier that many treatment and probation professionals felt was out of their control to address. Both treatment and probation professionals discussed the challenges of working with clients who live with family members or friends who continue to use or who try to get the client in trouble. Having a lack of support from peers in recovery is a major limitation to one's ability to stay in recovery (Cloud & Granfield, 2008). Professionals also talked about the client's community environment and how rural communities in particular seem to challenge people in recovery since everyone knows their past and seems to either reject them or pressure them to continue using. Professionals mentioned that clients in this stuck situation are pressed to either move away from family and long-time friends or stay in the environment, risking relapse.

Lack of education/training (treatment: 4/9; probation: 1/9) was presented as a system-level barrier most by treatment professionals who noticed the limited understanding people in the client's life have about addiction and recovery. This was talked about regarding both the individual's family members or spouse and the greater community. In order to change to a ROSC model, subsystems must be informed as a way to maintain the recovery environment in non-treatment settings as well.

Discussion of Research Question 3

Again, system-level factors stand out as essential in facilitating ROSC model practices for the probation professionals. Of all meaning units coded as facilitators, 41% emerged from the treatment sample and 59% from the probation sample. Of the meaning units coded as facilitators from interviews with treatment professionals, 50% were at the individual level and 50% at the system level. Of the meaning units coded as facilitators from interviews with probation professionals, 41.5% were at the individual level and 58.5% at the system level. In the discussion of individual and system level facilitators, dominant themes were defined as eight to nine interviews mentioning the theme while main themes were defined as four to seven interviews mentioning the theme. Three or fewer interviews mentioning the theme were qualified as “some” professionals in the description of the results.

Individual-level Facilitators

Analysis specified a few individual-level facilitators experienced by treatment and probation professionals in this sample. Meaning units coded as facilitators at the individual-level were fairly evenly split with those coded as system-level facilitators, however, probation professionals did experience individual-level facilitators to a lesser degree than system-level facilitators. From the individual facilitators emerged three subthemes that were main themes in all cases except one: *autonomy* (treatment: 5/9; probation: 6/9), *desire for successful outcomes* (treatment: 4/9; probation: 6/9), and *job experience* (treatment: 4/9; probation: 3/9).

Autonomy (treatment: 5/9; probation: 6/9) is a powerful facilitator at the individual level in the context of the substantial amount of meaning units coded as individual-level, ROSC model alignment in this data. Autonomy has the flip side 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).

Desire for successful outcomes (treatment: 4/9; probation: 6/9) was a promising subtheme to find from both treatment and probation professionals. This is a clear facilitator for implementation to the ROSC model as it primes the individual professional to want to do what's best for the client. From this data we know that not all professionals in these two systems of care are in line with all ROSC principles and elements, however if they truly have a desire for the client to be successful, they should be receptive to learning more effective perspectives to take in helping a client find success in recovery. This was demonstrated as told by probation professionals when there was a systemic shift away from punitive tactics toward evidenced-based practices and many probation officers embraced the change and accepted it as best for the client.

Job experience (treatment: 4/9; probation: 3/9) was an individual-level facilitator opposite the individual barrier of early development. Both treatment and probation professionals described the benefits of having time on the job to better understand what to expect and how to respond when working with clients and other professionals in the system. Again, most notable

from this subtheme is how professionals described old ways of thinking in line with acute-care and matured ways of thinking in line with the ROSC model.

System-level Facilitators

Meaning units coded as system-level facilitators experienced by treatment and probation professionals were fairly evenly split with those coded as individual-level facilitators. Probation professionals, however, did experience system-level facilitators to a greater degree than individual-level facilitators whereas treatment professionals mentioned system-level facilitators just as much as individual-level. From the meaning units coded as system-level facilitators, three subthemes emerged that were either dominant or main themes in all cases except two:

professional collaboration (treatment: 9/9; probation: 9/9), *supportive workplace environment* (treatment: 3/9; probation: 6/9), and *creative/grant funding* (treatment: 3/9; probation: 5/9).

Professional collaboration (treatment: 9/9; probation: 9/9) was a dominant theme among treatment and probation professionals. The ideas expressed around this subtheme were 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. Additionally, collaboration seemed to open the 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).

Supportive workplace environment (treatment: 3/9; probation: 6/9) was an important system-level facilitator for some treatment professionals and many probation professionals. It was described that having coworkers to turn to in challenging situations helped prevent burnout and establish a feeling of teamwork and unity. This facilitator would be important for a transition to the ROSC model as it would take support and a sense of unity to overhaul practices within and between systems. This could also aid in maintaining change based on accounts from probation professionals that they are able to help coach one another in the motivational interviewing skills learned and other evidenced-based practices. This supportive, team-based environment would facilitate accountability and unity in efforts toward a ROSC model.

Creative/grant funding (treatment: 3/9; probation: 5/9) was an important facilitator on the system level for many probation professionals and some treatment professionals. This facilitator is a fitting response to the system-level barrier of having inadequate funding available. It shows that even during financial crisis, money can be found in less conventional ways. One probation professional described her work in creating a pool of funds to finance client services in times of need, and she did this by reducing some staff hours and taking on a bit more of her staff's work. Because of this creativity, the probation officer's clients have better access to treatment and other necessary services when they can't afford it themselves or through other means in the community. As mentioned prior, sharing the load of grant writing and receipt of grant funds between treatment and probation systems was another effective way to maximize financial resources to benefit the clients. These examples are promising for other systems seeking to move toward a ROSC model during time of limited access to money.

Strengths and Limitations

As a qualitative study, this research had strength in several areas including interviews being conducted by the primary investigator, cross coding, and efforts to build trustworthiness through member checking and having accountability for biases. This study provides a closer look at the two systems of treatment and probation, which are often involved with one another at least at the basic level of having mutual clients, and would both necessarily be a part of system-wide transformation in moving to a ROSC model. This is an important investigation as many clients in substance use treatment are attending due to court mandate (White, 2008; SAMHSA, 2015), and many probation professionals in this study acknowledged the high level of cases they had that were somehow related to substance use. Because treatment and probation service providers often communicate and collaborate on cases it is essential that the two systems be considered together when exploring alignment with the ROSC versus acute-care model as well as the barriers and facilitators to moving toward a ROSC model.

Being the interviewer and primary investigator, there are some limitations to consider in design. By being a therapist myself, I was an insider to the treatment sample and informed by that system of care. My status as a therapist likely helped me to get more open and honest answers from treatment professionals and probably limited the openness of probation staff I interviewed. Further it is likely I wasn't as curious while interviewing the treatment professionals since I knew them and found very few surprises in their responses, whereas I had much fewer expectations going into interviews with probation officers and found myself quite curious.

It is limiting that this research does not reveal within-system factors such that differences within participants could be known. This is a limitation since the results presented from this data come from averages that could be skewed by one or two people mentioning

themes multiple times and the rest mentioning them minimally, for example. Without the within system factors outlined, it isn't possible to connect findings with participant demographic factors such as years of experience or type of probation officer. During the member checking process the probation administrator spoke to the differences she expected between probation professionals from different agencies, and how she knows her agency to be more evidence based than others. Another limitation to these results comes from the homogeneity of the participants and the environment. Some of these findings are likely unique to the rural Midwest while other factors could emerge as unique within a more diverse and urban setting. Without further exploration of other community systems, these results cannot be completely generalized to all systems. Finally, it is limiting that this data captures only part of an entire community system. Interviewing other subsystems such as the clients and their families or the judges would provide a richer understanding of the systems of care.

Implications and Future Directions

There are high demands in moving to a ROSC model from the acute-care model, but they might be less demanding than we think. Many elements of the ROSC model are already happening in the probation and treatment systems most of which include services that are person-centered, individualized, and integrated. It's important to note that codes for person-centered services did not include many other related codes such as services having cultural dimensions and responsive to personal belief systems. Not all subsystems of the professionals in this study demonstrated these elements, however, a majority of the professionals and their systems described fit within the ROSC model more than the acute-care model. This alone is a promising finding for the potential in these systems to implement a ROSC model.

Findings from this study open up implications for practice in taking steps toward a ROSC model. At a basic level treatment and probation professionals can strengthen their efforts in collaboration. This was a key system-level facilitator that relates closely to building integrated services. Collaboration is a starting point to alleviate the disjointed and untimely services described as a system level barrier and it naturally brings systems closer together as the professionals learn more about the other systems in place that the client is working within. Collaboration efforts are also likely to build unity between systems and continuity of care, which is an important step in preparing for a full transformation to the ROSC model where all systems must be on board (Kirk, 2010). The more professionals can work together to get on the same page the more likely a successful transition to the ROSC model can happen.

Building integrated services seems essential to invest in for implementing the ROSC model. The facilitators of professional collaboration and creative/grant funding shared a link to integrated services such that many of these facilitator codes emerged from talk about the shared position between the community mental health center and one of the probation agencies. This shared position was an addiction-based case manager that was employed with both agencies as a result of the joint grant writing efforts of the two. Both treatment and probation professionals spoke to the opening of opportunities for collaboration this shared position provided. Because the professional in this shared position had ties to both treatment and probation service systems it was also easier to resolve conflicting goals or disagreements between probation and treatment professionals. In addition, if services can be integrated on a larger scale, high workplace demands might decrease as the amount of directions a service provider is pulled in would lessen, and eventually the forms, procedures, and policies would be compatible (not necessarily uniform) across systems, providing greater continuity of care. Many current systems of care act

independently without knowledge or consideration for the other systems in place and how this ultimately impacts the client. This contributes to the gaps in care, and it seems essential to address in moving toward a ROSC model.

Change is difficult, and transforming entire systems of care takes energy and persistence. As a result of this data, it would be important for subsystems to rely on their strengths first when moving to a ROSC model. For example, probation professionals had a high level of system-level factors contributing to their model alignment. It was discussed that this might be due to the multiple rules and structures surrounding the probation system. Because the system-level factors seem to have great power in influencing the work of probation professionals, it would seem most fitting to address change first at the system level at least in the probation service system. Taking this step would involve getting agreement to do so among leaders of different supervising agencies. It would take education first at the very top of the systems so these changes could be promoted and maintained through individual probation professionals. For treatment professionals, this might necessarily look different as most of their codes for alignment with the ROSC model were at the individual-level. Because therapists have more autonomy in the work they do, change may begin at the individual level while a structure is built within the system to hold treatment professionals accountable for evidenced-based practice and other ROSC elements. This individual-level effort could include inviting family and allies to join relevant treatment sessions, create opportunities to collaborate more with other professionals by meeting with them at their office or inviting them to come to a treatment planning session with the client. These measures can begin to open the door toward further integration and implementation of ROSC model elements.

Finally, for both treatment and probation professionals changing to the ROSC model would require a level of accountability built. A lot can be learned from the changes already made at the system level for one of the probation agencies and how they have implemented supervision practices to monitor the skills of probation officers and coach skills to maintain fidelity in evidenced based practices, or EPICS as they were called. This seemed to be a missing link in the treatment system as well as other probation agencies. Without follow up training or ongoing accountability in some way, the service systems will naturally drift back to the status quo. This was found to be true in other systems implementing the ROSC model (Boyle et al., 2010). This piece of accountability, training, and follow up can also address the individual barrier of early development found in the treatment sample.

Implications for Couple and Family Therapists

As systems thinkers, couple and family therapists (CFTs) are in a unique position to drive change in treatment systems toward a recovery-oriented system of care. Further, CFTs have the training and education to refine this model of care to maximize the effectiveness of its systemic characteristics. For example, CFTs in both academic and clinical positions can advocate for the ROSC element, “inclusive of family and other ally involvement” becoming more comprehensive such that people in recovery are not being treated as individual problems with supportive others as witnesses, but are getting access to family systems therapy to address the problem of addiction at this system-level. Family life educators with training as couple and family therapists can engage with probation systems and judicial systems to educate on systems theory and discuss implications for policy, practices, and prevention efforts in their communities. CFTs can also be in contact with legislators to advocate for policies that improve ease of access to funded family therapy. Finally, CFTs could pioneer a call to action for service providers, community leaders,

and administrators to open discussions with the very public they serve. CFTs have the potential to lead movement toward recovery-oriented systems, and are equipped to engage in the collaboration necessary with clients themselves and other key players.

Future Research Needs

It's essential that clients receive services that are helpful to them and that outcomes can be tracked such that the ROSC model can continue to be refined. Because of the chronic nature of addiction, many clients will need to return to services at some point in their life, and services they receive initially will inform their level of comfort with returning, if they do at all. We must take a close look at the practices in place and critically consider the benefits presented by the ROSC model. Future research is needed to make comparisons within service systems of treatment and probation to capture the specific barriers and facilitators at work for the differing agencies. The fields invested in addiction and recovery services would benefit from knowing specifically what differences exist between the multiple probation and treatment agencies such as access to resources, quality of skills training, and location within other governing systems. Because there are different agencies doing similar work with clients, but governed by different entities, this is a necessary area of exploration. Additionally, it would be useful to explore these research questions with other, more diverse communities. Each community will likely hold unique barriers and facilitators for a transition to the ROSC model. Finally, it would be useful to gather the perspectives of other subsystems beyond treatment and probation since all would be involved in a transformation to ROSC. This could include researching the medical system, insurance companies, the clients themselves, law enforcement, and judges. Gathering additional perspectives would enrich our understanding of these systems of care.

Conclusion

Recovery from addiction is possible, but without certain supports in place within the community it can be an overwhelming challenge for individuals. Thus, the ROSC model offers a comprehensive solution to meeting the needs of people in recovery. Although professionals in the treatment and probation fields take care in the work they do with clients and have many ideas in line with the ROSC model, some acute-care characteristics linger and could continue to exist without intervention. In the cases where system-wide change to a ROSC model is not a present reality, it's up to the power of the individuals on the ground level of service systems to work together for creative ways to maximize the possible reaches of recovery-oriented principles and elements. Ultimately this creates gain for the whole community, healthcare system, and the clients and families in recovery. The acute-care model did have its place at one time for providing help to clients overcoming addiction. This model performed the best it could for these clients, but now it's time for more. We know better the complexities of addiction and recovery, and 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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Appendix A - Interview Guide

Interview Questions for probation officers, case manager, and therapists:

Questions gauging alignment with model:

1. How much time do you usually expect to work with a client once they begin services?
2. What do you see as your role in working with the client?
 - a. Who or what do you feel most loyal to in your role?
 - i. Where do you think this loyalty stems from?
3. How would you describe your approach to working with clients on probation/in substance use therapy?
 - a. What are your top priorities when you work with a client?
 - b. What are some of the hopes you have for clients when they enter services/probation?
 - c. What goals do you look for the client to achieve by the end of your time together?
 - d. How might your approach change depending on the client?
 - e. How has your approach changed over time?
4. Who are the key players in the client's success?
5. Who, if anyone, outside of the client do you make efforts to engage with to help the client meet their goals?
 - a. How did you come to decide to work with these contacts?
 - b. Are they always the same contacts?
 - c. What happens if these contacts don't share the same ideas about what's best for the client?
6. Describe a time you engaged with another professional in your client's life and this seemed to be an integral part of the client's success with you?
7. Describe a time a client left your care/supervision and you felt confident they had what they would need to maintain a healthy status in the community.
8. How would you describe the division of responsibility for the client's success?
9. What do you see in the client when you can tell they have reached a place of readiness to transition out of your supervision/therapy?
10. What are some catalysts you've seen for a client's successful recovery?
11. What factors do you believe are necessary for the client to do well in the community after working with you?
 - a. What factors does your organization believe to be necessary?
12. How do you make meaning of people who cycle back through treatment/probation? What sort of thoughts go through your mind?

Questions gauging barriers/facilitators:

13. In your ideal situation, without any structural or perceived barriers, how would your approach to working with clients look similar or different to how it is now?
14. What are aspects of your job culture that foster your ideal way of working with clients?
 - a. (Probe for intrinsic worldview vs structural limitations)

15. What are some of the barriers currently that keep you from acting in your ideal way?
16. In what ways does your supervisor support the approach you take with clients? In what ways does your supervisor challenge the approach you take with clients?
17. What professional challenges do you face when trying to do your best work with clients?
 - a. Policies
 - b. Colleagues
 - c. Time
 - d. Resources
 - e. Support
 - f. Structure
 - g. Collaboration
18. What comes to mind if I say you have one wish for how services you provide could be?
19. To what degree are you aware of the acute-care model of treatment services?
20. To what degree are you aware of the recovery-oriented systems of care model of treatment services?
 - a. If you are familiar, how did you learn of these treatment models?
 - b. If you are familiar, to what degree do you agree with these treatment models?

Interview Questions for Administrators:

Questions gauging alignment with model:

1. How long do you usually expect clients to be using your services after they begin?
 - a. Does the involvement of the service provider change over time in providing these services?
2. What role does your organization have in relation to clients?
 - a. What drives your organization most in decisions about client care?
3. How would you describe the approach your service providers have in working with clients on probation/in substance use therapy?
 - a. What are the top priorities your organization has with clients?
 - b. What goals should these clients be achieving by the end of their time in services?
 - c. To what degree have these goals or priorities changed over time?
4. Who do you view as the key players in the client's success?
5. Who, if anyone, outside of the client are service providers engaging with to help the client meet their goals?
 - a. How did this engagement come to be?
 - i. (policy, shared goals, service provider-driven)
 - b. Is it an expectation that service providers engage with these contacts?
 - c. What happens if these contacts don't share the same ideas about what's best for the client?
6. When would you feel confident a client has what they need to maintain a healthy status in the community outside of these services?

7. What expectations do you have of service providers helping clients transition out of supervision/therapy?
8. What are some catalysts you've seen for a client's successful recovery?
9. What factors do you believe are necessary for the client to do well in the community after receiving these services?
10. How do you make meaning of people who cycle back through treatment/probation? What sort of thoughts go through your mind?

Questions gauging barriers/facilitators:

11. In your ideal situation, without any structural or perceived barriers, how would your organization's approach to working with clients look different or similar to how it is now?
 - a. (Probe for intrinsic worldview vs structural limitations)
12. What are some of the barriers currently that keep your organization from acting in your ideal way?
13. What currently helps your organization move toward acting in your ideal way?
14. What are aspects of your community that foster your ideal vision for services to clients?
15. To what extent do service providers seem to follow through with expectations you have for their work with clients?
 - b. What are your guesses for why this is so?
16. What challenges does your organization face when trying to provide the best services to clients?
 - c. Policies
 - d. Colleagues
 - e. Time
 - f. Resources
 - g. Support
 - h. Structure
 - i. Collaboration
17. What comes to mind if I say you have one wish for how services you provide could be?
18. To what degree are you aware of the acute-care model of treatment services?
19. To what degree are you aware of the recovery-oriented systems of care model of treatment services?
 - a. If you are familiar, how did you learn of these treatment models?
 - b. If you are familiar, to what degree do you agree with these treatment models?