Taking Stock: Comparing Probation and Treatment Systems on Recovery-Oriented Characteristics

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Learning Objectives

1. The participant will be able to describe differences between the recovery-oriented systems of care and acute-care models.

2. The participant will compare the model characteristics highlighted from interviews with probation officers and those from interviews with treatment providers.

3. The participant will take away a set of next steps in developing, identifying, and maintaining recovery-oriented practices in their home community.
Introduction
Background

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

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

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

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

Addiction Treatment and Recovery Service Models

**ACUTE-CARE MODEL**

- Has dominated substance use treatment to date
- Effective at providing crisis management and stabilization
- Brief treatment model focused on alleviating symptoms
- Primary goal is abstinence

**RECOVERY-ORIENTED SYSTEMS OF CARE MODEL**

- An emerging model of care
- Initial evidence for effectiveness at reducing costs to communities and increasing positive outcomes for clients
- Defined by “networks of organizations, agencies, and community members that coordinate a wide spectrum of services...” (Sheedy & Whitter, 2013, p. 227).
- Primary goal to support long-term recovery
Current Gaps in Treatment

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

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

Service Characteristics (White, 2008; White & McLellan, 2008)
- Decision-making dominated by the professional
- Short-term service relationship
- Expectation of complete resolution of the problem post-treatment
- Services delivered in a uniform series often consisting of
  - Screening
  - Admission
  - Initial assessment
  - Treatment
  - Discharge
  - Termination of service relationship
- Re-entry into treatment is interpreted as a failure on the part of the individual rather than inadequate treatment design
# ROSC: 12 Guiding Principles of Recovery

*(Sheedy & Whitter, 2013)*

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<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>There are many pathways to recovery.</td>
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<td>2.</td>
<td>Recovery is self-directed and empowering.</td>
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<td>3.</td>
<td>Recovery involves a personal recognition of the need for change and transformation</td>
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<td>4.</td>
<td>Recovery is holistic.</td>
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<td>5.</td>
<td>Recovery has cultural dimensions.</td>
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<td>6.</td>
<td>Recovery exists on a continuum of improved health and wellness.</td>
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<td>7.</td>
<td>Recovery emerges from hope and gratitude.</td>
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<td>8.</td>
<td>Recovery involves a process of healing and self-redefinition.</td>
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<td>9.</td>
<td>Recovery involves addressing discrimination and transcending shame and stigma.</td>
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<td>10.</td>
<td>Recovery is supported by peers and allies.</td>
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<td>11.</td>
<td>Recovery involves (re)joining and (re)building a life in the community.</td>
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<tr>
<td>12.</td>
<td>Recovery is a reality.</td>
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# 17 Elements of ROSC Services

(Sheedy & Whitter, 2013)

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<tbody>
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<td>1.</td>
<td>Person-centered</td>
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<td>Inclusive of family and other ally involvement.</td>
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<td>3.</td>
<td>Individualized and comprehensive services across the lifespan</td>
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<td>Systems anchored in the community</td>
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<td>Responsiveness to personal belief systems</td>
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<td>10.</td>
<td>Commitment to peer recovery support services</td>
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<td>11.</td>
<td>Inclusion of voices and experiences of recovering individuals and families</td>
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<td>12.</td>
<td>Integrated services</td>
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<td>13.</td>
<td>System-wide education and training</td>
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<td>14.</td>
<td>Ongoing monitoring and outreach</td>
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<td>Outcomes driven</td>
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<td>16.</td>
<td>Research-based</td>
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<td>17.</td>
<td>Adequately and flexibly financed</td>
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Research Questions

1) Do the beliefs about treatment held by clinicians, probation officers working with offenders, and administrators overseeing these services align more with aspects of the acute-care model or the recovery-oriented systems of care model?
   - Where do these beliefs come from and to what degree is this a function of the current system of care in place?

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

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

Semi-structured individual interviews

Purposive sampling methods

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

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

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

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

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

TREATMENT PROFESSIONALS
Average age: 37
Average years in profession: 6
Average years in role: 3
Males: 3
Females: 6
Therapists: 7
Administrators: 2

PROBATION PROFESSIONALS
Average age: 43
Average years in profession: 20
Average years in role: 12
Males: 4
Females: 5
Probation officers: 3
Diversion Officer: 1
Parole Officer: 1
Case Manager: 1
Administrators: 3
Data Collection

All participants interviewed individually by primary investigator
  ◦ Approximate interview time: one hour
  ◦ Range: 35 to 77 minutes

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

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

Deductive approach

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

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

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

Each transcript was analyzed by two coders
  ◦ As primary investigator, I coded every interview and partnered with my research team members who were assigned to code the interviews they were responsible for transcribing.

Accountability for Biases
  ◦ Open discussion of reactions to interviews and other perspectives to consider

Researcher reflexivity
  ◦ Self-reflection
  ◦ Research team reflections

Member checking
  ◦ Key informants selected to review summary of results and comment on fit with their lived experience
Results
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?

Alignment Results:

Treatment Professionals -----------9/9 interviews described greater alignment with ROSC
Probation Professionals -----------8/9 interviews described greater alignment with ROSC
RQ 1a) Where do these beliefs come from and to what degree is this a function of the current system of care in place?

INDIVIDUAL LEVEL

Personally identifying with practices, policies, and beliefs regarding substance use treatment.

- Indicated by statements such as, “for me personally”, “this is how I see things”, or “my preference would be...”

SYSTEM LEVEL

Identified aspects of the systems within which individuals operate and are subject to

- Indicated by statements such as, “the way we were trained”, “that’s just how things work at...”, or “we are expected to...”
RQ 1a) Where do these beliefs come from and to what degree is this a function of the current system of care in place?

**INDIVIDUAL LEVEL**

*ROSC Codes (77% of ROSC codes)*
- Treatment Sample: 55%
- Probation Sample: 45%

*Acute-Care Codes (52% of Acute-care codes)*
- Treatment Sample: 22%
- Probation Sample: 78%

**SYSTEM LEVEL**

*ROSC Codes (23% of ROSC codes)*
- Treatment Sample: 34%
- Probation Sample: 66%

*Acute-Care Codes (48% of Acute-care codes)*
- Treatment Sample: 37%
- Probation Sample: 63%

"for me, personally"

"the way we were trained"
Models: Individual Level Exemplar Quotes

ROSC Model
- Treatment Professional: “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.”

- Probation Professional: “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.”

Acute-Care Model
- Treatment Professional: “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.”

- Probation Professional: I think sometimes my personal opinion [...] 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."
Models: **System** Level Exemplar Quotes

**ROSC Model**
- Treatment Professional: “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.”

- Probation Professional: “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.”

**Acute-Care Model**
- Treatment Professional: “and all the powers that be aren't going to authorize outpatient treatment for a year.”

- Probation Professional: “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.’”
<table>
<thead>
<tr>
<th>ROSC Principles:</th>
<th>Treatment %</th>
<th>Probation %</th>
<th>Total #</th>
<th>% of ROSC</th>
</tr>
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<tbody>
<tr>
<td>Many pathways</td>
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<td><strong>Self-directed/Empowering</strong></td>
<td><strong>62</strong></td>
<td><strong>38</strong></td>
<td><strong>140</strong></td>
<td><strong>10</strong></td>
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<td>Recognition of need for change</td>
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<td>Cultural dimensions</td>
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<td>Continuum of improved health</td>
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<td>82</td>
<td>6</td>
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<td>Emerges from hope</td>
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<td>Healing and Self-redefinition</td>
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<td>Transcending shame and stigma</td>
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<td>Supported by peers and allies</td>
<td>75</td>
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<td>Re-joining life in community</td>
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<td>Recovery is a reality</td>
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<td>.2</td>
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<td><strong>Totals for ROSC Principles:</strong></td>
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## Most Mentioned ROSC Principles

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Exemplar Quotes: ROSC Principles

Self-directed/Empowering

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

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

Holistic

- Treatment Professional: “One of the things that I would consider necessary to have for them to complete successfully, is to make sure that they have that system of care in place. In that, when they enter treatment here, we're not just looking at one aspect of them, that we're looking at all aspects, and all the systems that they have into play. You know, not only the addictions piece but the mental health piece, the physical health piece.”
<table>
<thead>
<tr>
<th>ROSC Elements</th>
<th>Treatment %</th>
<th>Probation %</th>
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<td>Person-centered</td>
<td>57</td>
<td>43</td>
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<td>Individualized/comprehensive</td>
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<td>Anchored in the community</td>
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## Most Mentioned ROSC Elements

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Exemplar Quotes: ROSC Elements

**Person-centered**

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

**Individualized/comprehensive**

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

**Integrated services**

Probation Professional: “Some of the people who are in intensive outpatient, well we go to wraparound monthly, but they're having contact with those treatment providers on a regular basis, which is something that has evolved over time too, we didn't, use to know whether people were going to treatment or not, and now we have a combined position with the community mental health center, a shared position.”
<table>
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<tr>
<th>Acute Care Subthemes:</th>
<th>Treatment %</th>
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<th>% of Acute</th>
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<td>Prompted by crisis</td>
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<td>Brief treatment/intervention</td>
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<td>Short-term service relationship</td>
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<tr>
<td>Re-entry interpreted as failure</td>
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<td>Lack of research-informed care</td>
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<td>Few connections to non-treatment</td>
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<td>Lacking follow up post-treatment</td>
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## Most Mentioned Acute-Care Subthemes

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<td>24</td>
<td>76</td>
<td>70</td>
<td>25</td>
</tr>
</tbody>
</table>
Exemplar Quotes: Acute-Care Subthemes

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

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

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

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

### ROSC Model Totals:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Total #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment%</td>
<td>52</td>
<td>1,381</td>
</tr>
<tr>
<td>Probation%</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>% Model Codes</td>
<td>83</td>
<td></td>
</tr>
</tbody>
</table>

### Acute-Care Model Totals:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Total #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment%</td>
<td>30</td>
<td>281</td>
</tr>
<tr>
<td>Probation%</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>% Model Codes</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>
Discussion
Discussion: Research Question 1

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

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

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

Overall, these findings help clarify the
- essential role of the individual professional in establishing and maintaining the ROSC model
- unique influence the probation system has in driving services
RQ 1 Discussion: Model Alignment

**ROSC Codes**
- Treatment: 52%
- Probation: 48%

**Acute-Care Codes**
- Treatment: 30%
- Probation: 70%
RQ 1 Discussion: **Individual Level Influence**

**ROSC codes**
- 77% associated with individual-level factors
  - Treatment professionals contributed 55%
  - Probation professionals contributed 45%
- The practices, values, ideas, and beliefs of individuals in this treatment community are primed for a transition to the ROSC model

**Acute-care codes**
- 52% were associated with individual-level factors
  - Probation professionals contributed most to the individual-level acute care codes (78%) in comparison to treatment professionals (22%), which suggests the importance of implementing change strongly at the probation system level to shape and support individual professionals in transitioning to the ROSC model.
RQ 1 Discussion: System Level Influence

Differences between systems

- Probation professionals
  - Had more system-level codes than treatment professionals for both ROSC and acute-care.
  - May be due to probation professionals having to work within less flexible bounds compared to treatment professionals. Probation professionals have more rules and guidelines to follow, more systems to answer to, and are ultimately bound to their role in law enforcement.

- Treatment professionals
  - Treatment professionals have quite a bit of autonomy in their day to day work and are only answering to the ethics of their practice, which are client-centered in the first place.
  - Although treatment professionals contributed more to the individual-level alignment with ROSC, their perceptions of the larger systems of care contributed to the ROSC alignment less in comparison to probation professionals.

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.
What does a recovery-oriented corrections system look like?
Strengths

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

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

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

Lack of Within-System Comparisons
- Cannot speak to differences between professionals or agencies
  - Can’t connect findings with demographics such as age, development, training, etc

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

Among all systems
- Collaboration is an essential step in building integrated systems toward a ROSC model

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

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

Barriers

◦ What barriers get in the way of a recovery-oriented system?

What does this look like without proper funding?

◦ Social responsibility for advocacy and follow through?
Goals for increasing recovery-oriented practices within your system of influence
Future Directions

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

Expanding investigation to other, more diverse communities
- Each community will likely hold unique barriers and facilitators for a transition to the ROSC model

Gather the perspectives of other subsystems beyond treatment and probation
- Medical system
- Insurance companies
- Clients
- Law enforcement
- Judges
Advances in tracking recovery-oriented practices

Recovery-Oriented Services Assessment (ROSA)
  ◦ Lodge, Kuhn, Earley, & Stevens Manser (2018)

15-item measure developed for both staff and people in services to assess degree of recovery-oriented services
  ◦ Developed with peer-recovery consultants
Conclusion

- Recovery from addiction is possible, but without certain supports in place within the community it can be an overwhelming challenge for individuals.

- The ROSC model offers a comprehensive solution to meeting the needs of people in recovery.

- Treatment and probation professionals express good intentions that are mostly aligned with the ROSC model, but some aspects of the acute-care model linger.

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


References Contd.


