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Coping with Addiction: A Case Study Exploring the Needs of Struggling Substance Abuse Addicts

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Coping with Addiction: A Case Study

Exploring the Needs of Struggling Substance Abuse Addicts

by

Shelly Wims

A Dissertation submitted to the Education Faculty of Lindenwood University

In partial fulfillment of the requirements for the

Degree of

Doctor of Education

School of Education

Coping with Addiction: A Case Study

Exploring the Needs of Struggling Substance Abuse Addicts

by

Shelly Wims

This dissertation has been approved in partial fulfillment of the requirements for the degree of

Doctor of Education

at Lindenwood University by the School of Education

Francesco Giuseffi	October 8, 2021
Dr. Francesco Giuseffi, Dissertation Chair	Date
Lynda Leavitt, EdD	October 8, 2021
Dr. Lynda Leavitt, Committee Member	Date
Robyne Elder	10/08/2021
Dr. Robyne Elder, Committee Member	Date

Declaration of Originality

I do hereby declare and attest to the fact that this is an original study based solely upon my own scholarly work here at Lindenwood University and that I have not submitted it for any other college or university course or degree here or elsewhere.

Full Legal Name: Shelly Wims

/

Signature: Shelly Wims Date: 08/30/2021

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Abstract

The purpose of this qualitative case study was to explore the current State Targeted Response (STR) Program in a Midwest recovery program that addressed increases in opioid abuse and barriers to recovery. The study sought to answer how substance abuse counselors detected and addressed potential barriers, if any, to addiction recovery; whether substance abuse counselors sought any need for improvements within the STR to reduce relapse; how counselors addressed the social aspects of addiction; whether counselors addressed the factors influencing addiction relapse; and whether counselors collected feedback from clients concerning their perception of the effectiveness of treatment in preventing addiction relapse. The theoretical framework of this research study was social cognitive theory, and the research methodology for the proposed study was the qualitative approach and a case study design. The researcher used the following data collection instruments: interview protocol, focus group protocol, secondary data collection form, and an audio tape. Six participants (six participants participated in one-on-one interviews and four of the six participants participated in focus group discussion) completed the study at an out-patient clinic in an urban city in the Midwest. Six themes emerged from the analysis: (1) assessments, (2) addressing barriers, (3) suggestions for improvement, (4) addressing social aspects, (5) addiction relapse, and (6) program effectiveness in preventing relapse. The study concluded with several recommendations for future research, such as studying programs in urban and rural areas and inclusion of client evaluation in the analysis.

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Chapter One

Introduction

Previous researchers estimated that more than 72,000 people have died from opioid overdose in the United States since 2017 (Yerby, 2020, p. 31). To address the opioid crisis, state targeted response grants have been provided to individual states in the country to develop interventions and programs to address problems related to opioid addiction, overdose, and deaths (Park & Otte, 2019; Scott et al., 2020; Shipton et al., 2018; Wagner et al., 2020). The implementation of state targeted responses to the opioid crisis have proven to be challenging for many states. Some of these barriers included budget, legislative issues, protracted hiring, and procurement problems (High et al., 2020).

The successful implementation of state targeted responses to the opioid crisis was affected by different barriers and challenges. These barriers focused on the prevention, treatment, and recovery aspects implementing the opioid crisis (High et al., 2020; Levin & Cates-Wessel, 2018; Reif et al., 2020). The reason for barriers was based on the existing challenges in the prevention, treatment, and recovery aspects implementing the state targeted responses to the opioid crisis. The current study focused on exploring the current state-targeted response program in an urban city in the Midwest in relation to the increase in opioid abuse and barriers to recovery.

In this chapter, the researcher introduced the research topic regarding state targeted responses to the opioid crisis. The following sections were included in this chapter: (a) rationale for the study, (b) purpose of the study, (c) research questions, (d)

theoretical framework, € nature of the study, (f) study limitation, and (g) definitions. The chapter concluded with a summary of the most salient points of the introduction.

Rationale of the Study

The current national drug addiction epidemic resulted from overuse and abuse of the use of opioids, a diverse class of strong drugs used to alleviate pain (Scanlon & Hollenbeak, 2019). Drugs, such as oxycodone and hydrocodone were classified as opioids in addition to opium-derived drugs, such as heroin and morphine (Kibaly et al., 2020). Despite the high risk of addiction and overdose, such drugs became a popular choice of both medical professions to treat patients suffering from chronic pain and recreational drug users. Between 1999 and 2017, over 700,000 people died from drug abuse (Center for Disease Control [CDC], 2018, p. 13). In 2017, more than 68% of drug-related deaths involved opioids and, by 2017, there was a significant increase in the number of deaths (~4,200,000) from the abuse of prescription and illegal opioids (CDC, 2018, p. 15). Despite the increase in federal and state-funded drug recovery programs available to address the opioid addiction epidemic, relapse was common among people who successfully completed in-patient and out-patient drug recovery programs. According to the CDC (2018), 60 to 90% of recovering drug addicts would relapse within 1 year following treatment due to stressors, such as family, friends, a shortage of money, and job-related issues.

There has been limited research identifying strategies to reduce relapse percentages, but the ones that were most effective in lowering relapse were usually the ones recovery programs seldom used (Giordano et al., 2014; Hendershot et al., 2011). The strategies included the use of interactive teaching methods designed to increase the

participant's emotional control capabilities and communication skills and personalized relapse prevention strategies (Giordano et al., 2014; Hendershot et al., 2011). Despite the availability of scientifically derived educational tools, traditional mental tools (counseling, psychotropic medications), and physical tools (housing, employment, transportation) provided to the patient, there was still a high risk of relapse among opioid addicts (Caputo, 2019; Davis et al., 2017; Kenney, 2019; Langley-Turnbaugh & Neikirk, 2018).

The researcher attempted to identify and address issues outside of the traditional focus that may have played a significant role in the long-term success or failure of out-patient rehabilitation. These issues included the educational value of the program, such as teaching coping mechanisms and how to identify personal triggers, the degree of impulsivity among participants, individually tailored treatment plans, and unaddressed environmental influences. If such barriers existed, the identification and classification of these barriers could assist the city in developing more expansive, long-term recovery programs and significantly reduce the return rate of participants.

Purpose of the Study

The purpose of this qualitative case study was to explore the current State Targeted Response (STR) Program in a Midwest recovery program that addressed increases in opioid abuse and barriers to recovery. Another aspect of this study was to create an educational plan for clinicians inclusive of teaching coping mechanisms, identifying personal triggers, and the unaddressed environmental influences.

Research Questions

The research questions of the study are the following:

Research Question 1: How do substance abuse counselors detect and address potential barriers, if any, to addiction recovery?

Research Question 2: What do substance abuse counselors view as improvements within the STR to reduce relapses?

Research Question 3: How do counselors address the social aspects of addiction adequately?

Research Question 4: How do counselors address the factors influencing addiction relapse?

Research Question 5: How do counselors collect feedback from clients concerning the effectiveness of treatment?

Theoretical Framework

The theoretical framework of the research study was social cognitive theory (Bandura, 2001) which hinged on the overarching theoretical assumption that behaviors were mutually influenced by the environment and the person, underscoring a reciprocal and mutual interaction with each other (Bandura, 2001). The researcher used the social cognitive theory to explore the current state targeted response program in the Midwest in relation to the increase in opioid abuse and barriers to recovery.

The three components of the triadic reciprocal determinism of Bandura (2001) posited were the person, environment, and behaviors. The person component of the model referred primarily to cognition but also included individual-based factors, such as perceptions, expectations, goals, and affect. The environment component pertained to any contextual factors, such as culture, social relationships, and family. Finally, the behavior component pertained to any inward or outward action controlled by punishment or

reward. All three components interacted with each other, which explained why a particular behavior manifested in a person within a specific environment.

The social cognitive theory had been used in several research studies focused on the different aspects of the opioid crisis (Gilbert et al., 2018; Lefebvre et al., 2020; Xu & Cao, 2020). For instance, Gilbert et al. (2018) utilized the social cognitive theory to assess the effectiveness of policies to reduce opioid overdose. Xu and Cao (2020) used the social cognitive theory to frame the use or misuse of prescription opioid drugs by young adults. Lefebvre et al. (2020) applied the social cognitive theory to frame the examination of health communication campaigns to increase the demand for evidence-based practices and decrease stigmatization regarding opioid addiction. Previous research studies highlighted the relevance and utility of the social cognitive theory in framing policies, behaviors, and implementation practices relevant to the opioid crisis.

Nature of the Study

The current research study utilized the qualitative approach, focusing on the exploration of perceptions and experiences of individuals in ways that were not restricted by a preconceived set of responses (Silverman, 2020). The qualitative research approach was appropriate for this study given the exploratory focus of the purpose, which required a stance of starting from the point of discovery as opposed to confirmation or validation. Qualitative research is not based on previously generated theories to confirm its empirical validity; instead, qualitative research starts from the words and experiences of the participants in order to make sense of a phenomenon (Flick, 2018).

The research study also utilized a case study design based on examining a complex phenomenon in its natural environment without manipulating the context

(Yazan, 2015). Another characteristic of case study research was the flexibility, both in terms of theoretical principles and methodological design (Yin, 2011). In other words, the case study research design was not constrained by a specific theoretical principle or a methodological approach to facilitate a type of study that was informed by the best approach to study a complex problem (Yazan, 2015). The case study research design was appropriate for this study because of the design's alignment with the exploratory, comprehensive, flexible, and participant-centered purpose of the current research study.

Study Limitations

There were several limitations to the research study. The participants in the study included addiction counselors who counseled at least one client who relapsed 3 months after completing the out-patient treatment program. The participants had to hold a state required licensure and/or certification as a drug addiction counselor. The exclusion of other stakeholders, such as state leaders, intervention designers, and other health care professionals meant the findings might not have been as comprehensive as intended. The location of the proposed research study was confined to a single site, described as an urban city's state targeted response program. The research study results might not be generalizable or applicable to other state targeted response programs in the Midwest and other regions of the United States, as the researcher will only explore the strategies that counselors based in Midwest adopt with their patients. The data sources for this study came from one-on-one interviews, focus groups, and secondary data. All of these data sources were qualitative in nature, which meant all data was in narrative format and could not be quantified or statistically analyzed (Silverman, 2020). The researcher did not collect quantitative data in the research study. This means that the findings from this

study were not fact-based and were based on counselors' perceptions only, as they centered around the personal experiences of counselors working with their clients.

Definition of Terms

To facilitate consistent understanding of key terms, the following definitions are provided in this section:

Detoxification

Detoxification refers to the period of treatment for drug or alcohol addiction wherein individuals are assisted with overcoming the negative physical and psychological effects of addiction (Levola et al., 2021). Detoxification also pertains to the process in which the effects of drugs or alcohol are eliminated in a safe manner in order to minimize the symptoms of withdrawal (Dunbar et al., 2021).

In-patient Detoxification

The term in-patient detoxification refers to the process of undergoing detoxification for drug or alcohol addiction wherein the individual is expected to be confined within a medical care residential facility under the supervision of experts (Hogan et al., 2018; Levola et al., 2021). This type of detoxification is often more appropriate in more severe cases of drug or alcohol dependence.

Medical Detoxification

Medical detoxification is considered the first step towards recovery from drug or alcohol dependence, wherein a safe environment is provided under medical supervision to facilitate the withdrawal from drugs or alcohol, which often entails experiencing various psychological and physical symptoms (Anderson et al., 2018).

Medication-Assisted Treatment (MAT)

MAT refers to the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders ("Addiction Treatment & Recovery Center - Muncie | IU Health"). A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some individuals to sustain recovery (Substance Abuse and Mental Health Service Administration [SAMHSA], 2017).

Opioid Use Disorder

Opioid use disorder refers to the maladaptive use of opioids, prescribed or illicit, resulting in two or more criteria that reflect impaired health or function over a 12-month period (Connery, 2017).

Out-patient Detoxification

The term out-patient detoxification refers to the process of undergoing detoxification outside the confines of a residential or medical facility, providing individuals with more flexibility in their treatment and recovery (Dunbar et al., 2021). Out-patient detoxification is often more appropriate in milder or more moderate alcohol or drug addiction cases wherein withdrawal symptoms are relatively manageable outside a medical facility.

Relapse

Relapse pertains to a setback that occurs during the behavioral change process of recovery, such that the progress toward the initiation or maintenance of a behavioral change goal (e.g., abstinence from drug use) is interrupted by a reversion to the target (Hendershot et al., 2011).

Relapse Prevention

The terms relapse prevention often refers to a cognitive–behavioral therapeutic approach, with the goal of identifying and preventing high-risk situations that could lead to relapse (Witkiewitz, 2014).

State Opioid Response (SOR)

SOR refers to a program that aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment needs, and reducing opioid overdose-related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder (SAMHSA, 2018).

State Targeted Responses (STR)

STR refers to a substance abuse program funded through grants intended to comprehensively address the opioid crisis (Substance Abuse and Mental Health Service Administration [SAMHSA], 2017).

Withdrawal

Withdrawal refers to a syndrome that is experienced during detoxification that ranges from mild symptoms, such as tremor or insomnia, to severe symptoms, such as delirium or seizures (Lantz et al., 2021).

Summary

The continued rise of opioid overdose-related deaths underscored the problem, which leads to state targeted response programs intended to address the opioid crisis (Yerby, 2020). The purpose of this qualitative case study was to explore the current State Targeted Response (STR) Program in the Midwest in relation to the increase in opioid

abuse and barriers to recovery. Another aspect of this research study was creating an educational plan for clinicians inclusive of teaching coping mechanisms, identifying personal triggers, and the unaddressed environmental influences.

The research study was important because the identification and classification of these barriers may assist state leaders in developing more expansive, long-term recovery programs and significantly reduce the return rate of participants. The theoretical framework of the research study was informed by the social cognitive theory (Bandura, 2001). The qualitative case study design was utilized for the current study and one-on-one interviews, focus groups, and secondary data were the sources of data (Yazan, 2015). The following are key sections will be discussed in the literature review: (a) literature search strategy, (b) background on opioid use disorder and drug addiction, (c) sociological theories of drug of addiction, (d) out-patient drug recovery programs versus residency drug recovery programs, (e) different state targeted response to the opioid crisis, and (f) barriers to the implementation of interventions and policies intended to address the opioid crisis.

Chapter Two: Literature Review

In this chapter, the researcher presents the literature review based on the analysis of previous research on opioid addiction and state targeted response to the opioid crisis. The following are the key sections that are included in the literature review: (a) literature search strategy, (b) the disease of addiction, (c) sociological theories of drug of addiction, (d) background on opioid use disorder and drug addiction, (e) counseling and medication as an integrative treatment for opioid addiction, (f) out-patient drug recovery programs versus residency drug recovery programs, (g) different state targeted response to the opioid crisis, and (h) barriers to the implementation of interventions and policies intended to address the opioid crisis. The researcher concludes the chapter with a summary of the literature review, focusing on the different themes that emerged from the analysis and evaluation of the current professional literature.

Literature Search Strategy

The literature search strategy that was used to write the literature review entailed researching several studies related to the overarching topic of state targeted responses to the opioid crisis and the barriers to recovery. Several online databases were used to search for relevant literature. These online databases included Google Scholar, JSTOR, PubMed, and CORE. Priority was given to research studies that were peer-reviewed and published no earlier than 2017.

Several keywords and phrases were used to search for relevant literature. These keywords and phrases included the following: *opioid use disorder, opioid addiction, opioid crisis, drug addiction, state targeted responses, barriers to recovery, prevention of opioid addiction, treatment of opioid addiction, integrative treatment, medical-assisted*

treatment, and interventions for opioid addiction. A combination of these terms was used to maximize the relevant output of the literature search in the online databases that were utilized for the literature review.

Sociological Theories of Drug Addition

Sociological theories centered on social structures and environmental differences such as weak family social bonds (Haghighatian & Hashemianfar, 2020; Wangensteen & Westby, 2021). The basis for social bonds theory focused on the assumption that humans were pre-disposed to wrongdoing, and the only thing that stopped humans from deviating from accepted social norms was the strength of social control and the depth of social bonds. In this case, social bonds included family attachments and a strong desire to please those, such as a mother, father, or younger siblings who looked to the older sibling for guidance and social cues. Humans needed to feel invested in maintaining acceptable social norms. There was also the need to maintain close friendships and, as the circle of friendships evolved, so did the strength of dependency on those friendship bonds. While the strength of these friendship bonds prevented deviant behavior, however, it also promoted such behavior (Wangensteen & Westby, 2021). To maintain positive social bonds required a level of commitment to maintain normal social norms. Moreover, the amount of time and effort one expended to maintain social norms strengthened the determination to avoid actions that jeopardized one's investment in certain behaviors (Haghighatian & Hashemianfar, 2020).

Lastly, there was some degree of belief that maintaining acceptable social norms resulted in positive gains, such as increased social standing via increased income that translated into a higher standard of living. Drug addiction had a negative impact on both

an individual and social level. Addictive behaviors were often explained using the principles of the social learning theory (Bandura, 2001), especially when dealing with young addicts. Most learning theories centered on how individuals absorbed and processed information or knowledge and how a person's environment influenced how they learned. Skinner's operant conditioning theory addressed how a person leaned through reinforcement or punishment (Akpan, 2020). In the case of drug addiction, if a person experienced a near death experience from an overdose, the person was less willing to take that drug for fear of a repeat of that negative response. The punishment could be the resulting stigmatism related to how members of the communities viewed drug addiction, which often meant being shunned, thus motivating the person to modify their behaviors (Akpan, 2020).

Self-medication theories attempted to explain the use of opioids and other highly addictive drugs as a means to enhance mood or to decrease emotional pain or discomfort. Observational learning also related to a person's need to emulate the behaviors of those they admired or held in high regard for various reason (Shams-Eldin et al., 2019). They may have been a person popular in the community or a person who was seemingly successful based upon their ability to obtain substances that may have been impossible for the emulator. One common denominator of each theory of drug addiction was the assumption the person was willing to change their behavior if they understood the psychological reason for their addiction and how addiction negatively impacted physical health, mental wellbeing, and personal relationships (Wiss, 2019). Based upon the steady increase in opioid use, however, and the high rate of relapse noted among the number of persons enrolled in rehab treatment programs—both long-term residency and out-patient

programs—traditional approaches based on one or more various social theories did not work (Wiss, 2019).

The reason for drug addiction extended beyond social, moral, and spiritual influences (Blanco et al., 2020). The cause of drug addiction was more than poor education concerning perception of the impact of opioid addiction on one's health. The lack of motivation to change destructive behavior or the failure of drug rehabilitation programs to address the differences between human behavior based on environmental factors such as race and gender were also identified as a possible cause of drug addiction (Cantu et al., 2020).

The Social Determinants of Health

According to the CDC (2019), social determinants of health (SDH) were the circumstances under which individuals live. There are no circumstances that guaranteed a person would become a drug abuser or a drug addict. Researchers linked SDH, however, to risk factors for opioid abuse and addiction (Blanco et al., 2020; Cantu et al., 2020; Fields-Johnson & Savannah, 2020; Weill, 2020). Such risk factors included a family history of drug abuse and addiction, as a person might have been predisposed to addiction or inherited a metabolism that processed certain drugs differently, which lead to addiction (Eaton et al., 2020). The risk of abusing drugs or developing an addiction increased when a person lived in a toxic environment. For example, in some communities, illegal drugs were readily available on the nearest corner or a few houses down the street (Cantu et al., 2020). People living in this environment were more likely to have friends who abused drugs or had family members addicted to drugs (Blanco et al., 2020; Cantu et al., 2020; Fields-Johnson & Savannah, 2020; Weill, 2020).

The Intersectionality of Drug Addiction

Crenshaw (1989) developed the theory of intersectionality. The theory formed out of the need to address the complexity of violence against women, in particular to the unique oppressions experienced by black women. The theory of intersectionality studied the social links between race, gender, age, and behavior (Rice et al., 2019). Intersectionality included sexuality, mental health, depression disabilities, class, geopolitics, and a number of other social categories developed over the past 20 years (Rice et al., 2019; Singh et al., 2020). According to Collins et al. (2019), researching the production of risk and harm in regard to drug abuse and addiction required the examination of the relationship between a large number of environmental factors that influenced behavior and created barriers to addiction (Collins et al., 2019; Pensmark et al., 2019).

Individuals often existed to perform different functions. For example, women dealt with all of the implications that came with being a female within society such as equal pay, relationship expectations, role models, support structures, motherhood, social standing, and discrimination (Brown et al., 2020; Caceres et al., 2019; Everett et al., 2019). Each of these elements affected how people coped with stress, fear, and loss of control. The theory of intersectionality highlighted the multiple and unique disadvantages experienced by certain groups that could not be isolated from one element to another (Brown et al., 2020; Caceres et al., 2019; Everett et al., 2019).

Relapse from Drug Recovery

There were various reasons a person experienced a period of relapse after completing an out-patient to residency drug recovery program. On reason was the

persistent craving for the drug of choice (Girardeau et al., 2019) once the drug became available. Recovery patients were often victims of over confidence, which expressed the false sense of self-control over one's actions and behaviors (Girardeau et al., 2019; Sliedrecht et al., 2019; Ruisoto & Contador, 2019). Relapse was the result of possessing unrealistic expectations, such as believing recovery patients could maintain abstinence within the same circumstances that initially resulted in developing drug addiction (Ruisoto & Contador, 2019). The pressure of unrealistic expectations from others in the community also drove drug relapse along with the frustration regarding the continual need to fight the need for drugs (Girardeau et al., 2019; Ruisoto & Contador, 2019; Sliedrecht et al., 2019).

Often, a person along with the community at-large viewed relapse as a sign of failure. Relapse was, however, considered a part of the drug addiction recovery process. According to the National Institute on Drug Abuse (NIDA, 2019), 40-60% of drug recovery patients experienced relapse at least once during the recovery process. Daily frustrations, stress, and emotional issues did not disappear at the completion of a recovery program, yet few were prepared to reenter the social context in which they lived and maintained sobriety (Ruisoto & Contador, 2019; Witkiewitz et al., 2019). Those within the criminal justice population were at the greatest risk for relapse.

Addiction in the Criminal Justice System

In 2018, there were approximately 6,410,000 persons incarcerated in prisons or jails across the United States (Bureau Justice, 2018, p. 3). More than 59% of these incarcerated had a history of addiction to alcohol, opioids and methamphetamines (Bureau Justice, 2018, p. 3). Within most U.S. prisons, there existed extensive and well-

organized drug trafficking operations, which allowed many prisoners the ability to make connections to purchase drugs to maintain their addiction while serving time (Cassidy & Rydberg, 2020). Most drugs were smuggled into prisons through the U.S. mail service, visitors, and, in many cases, underpaid prison security employees. Conditions within federal prison offered few incentives for individuals to seek drug addiction treatment during their incarceration, especially for those serving long prison sentences (Bucerius & Haggerty, 2019; Cassidy & Rydberg, 2020).

Prisoners who did seek treatment for their addiction may not have had access to available programs due to budget constraints at the state and federal level. One program available to inmates in most prisons was the medication assistance treatment program (MAT) that evolved into the gold standard for treatment for opioids addiction (Moore et al., 2019). Research indicated the use of drugs identified for treatment by the Food and Drug administration, in combination with counselling, vocation training, education, and behavioral therapy, provided a holistic approach to addiction recovery. The use of buprenorphine, methadone, and naltrexone for short and long-term addiction treatment improved the survival of addiction by reducing the use of opioids, which reduced the incident rate of overdose-related deaths. Medical assistance drug therapies improved patient retention in a treatment program. The longer a person remained in an addiction program, the greater the chances of a full recovery, allowing the patient to reenter society and become a part of the community. The MAT program was not, however, without controversy. One of the issues of utilizing the MAT as a means to treat opioid addiction was the risk the patient developed a new addiction to the drugs used. Buprenorphine, for

example, was highly addictive if not administered within and controlled where the patient was closely supervised (Linden et al., 2018; Moore et al., 2019).

Within the criminal justice system, fewer than 6% of incarcerated individuals had consistent access to MAT, especially in privately, or for-profit, controlled prisons (Montes et al., 2021, p. 4). Privately controlled prisons were administrated through third-party federal contacts who entered into contractual agreement and were paid a per diem or monthly rate based on the number of inmates housed (Omori, 2018). The end goal of state and federal prisons was to house those convicted of a crime through the criminal justice system. Another goal was to rehabilitate individuals so that they might successfully reenter society as a productive member of the community. By contrast, the main interest of private prisons was profit (Ortiz & Jackey, 2019). The increase of private prisons over the years could be directly linked to the federal funded "war on drugs" in the 1970s (Ortiz & Jackey, 2019). In an effort to address the rise in illegal drug use in the United States through increased penalties, the strict enforcement of current illegal drug laws and the incarceration of drug offenders intensified (Omori, 2018). In 1971, then President Nixon declared the use and distribution of illegal drugs a major threat to the country and significantly increased funding for drug control and treatment. The Drug Enforcement Administration (DEA) was created and combined with other drug enforcement agencies to control illegal abuse (Omori, 2018).

The Reagan administration expanded the drug program by incarcerating drug offenders due to the rise of offenders. Reagan's effort greatly increased the incarceration of nonviolent drug offenders during the crack epidemic occurring in urban cities across the country (Estévez-Lamorte et al., 2018). The Reagan administration established

mandatory sentences for various drug offenses, carrying the greater punishment of a minimum of 5 years in prison (Estévez-Lamorte et al., 2018). At the time, 80% of crack users were African American (AA), which resulted in a significant disparity in the percentages of those incarcerated (Benekos & Merlo, 2020, p. 91). Another problem with the war on drugs was that it mainly focused on the low-income urban area, which meant African Americans were adversely affected by the government's attempt to control the distribution and use of illegal substances. President Clinton's three strike-provision added to the crime bill, to further exacerbate the problem which increased the incarceration rates exponentially, resulting in proliferation of private prisons to reduce overcrowding within state and federal prisons (Gaes, 2019).

Currently, private prisons house 8.5% of all incarcerated individuals in the United States and have evolved into a structural, societal, and legal problem (Estévez-Lamorte et al., 2018). Structurally, to ensure healthy profits for stockholders, private prisons kept overhead costs at a minimum which meant reducing staffing levels, the services provided, and the number of inmates receiving services (Gaes, 2019). Reduced staffing made it difficult for the private prison systems to meet the demand for rehabilitation services, such as the MAT program, resulting in fewer inmates enrolled (Montes et al., 2021). Societally, the use of private prisons resulted in an increase in mass incarceration, especially among African Americans, and may have violated an individual's right to due process in an effort to maintain population numbers (Montes et al., 2021).

Although the criminal system presented a controlled environment that limited access to illegal drugs, most prisons had an active drug trade operation through the coordination between inmates, prison workers, and outside affiliates. Researchers

estimated that 80% of the general prison population had a drug addiction to alcohol or opioids (Bureau of Justice Statistics, 2019, p. 2). Either an individual entered the criminal prison system with an addiction or was exposed to drugs, such as opioids, during the course of their incarceration. Within the criminal system, an estimated 130 people per day died from an opioid overdose while incarcerated (North Central Behavioral Health Systems [NCBHS], 2018, p. 11). According to the National Council on Alcoholism and Drug Dependence (NCSDD, 2019), 60% of all inmates displayed signs or symptoms of addiction. These inmates could not function for long periods of time without the drug of their choice and would display behaviors linked to drug withdrawal, such as increased irritability, tremors, agitation, and physical discomfort (Caulkins et al., 2020). Unfortunately, less than 11% of inmates suffering from drug addiction received adequate treatment for their addiction and then released into the community after their time was served (National Institute on Drug Abuse [NIDA], 2018).

According to the NCBHS (2018), 40% of opioid-related overdose deaths among former inmates occurred within 2 to 3 years upon release from the criminal justice system. To address the high rate of opioid addiction within the criminal justice system, institutions employed the use of a Medication-Assisted Treatment program (MAT). The program used medications combined with counseling behavior therapies in an attempt to provide the individual with a holistic approach to combating addiction (SAMHSA, 2019). The Food and Drug Administration (FDA) approved the medications used in the MAT program to ease withdrawal symptoms and the psychological craving experienced by addicts. Buprenorphine, Methadone, and Naltrexone were the most common drugs used for opioid addiction (Moore et al., 2019; Puglisi et al., 2019). Buprenorphine suppressed

the urge or craving for opioids, while Methadone reduced cravings and the pain of withdrawal. Naltrexone blocked the euphoric effects of opioids (FDA, 2019; Moore et al., 2019). Federal law required persons receiving these drugs underwent counseling in conjunction with medical care, vocational training, educational service, and regular monitoring (FDA, 2019; Moore et al., 2019).

For many people exiting from the criminal justice system, relapse created barriers to reentry into the community and reconnection to family and other support systems. Healthcare and other social programs that assisted with reentry to society after incarceration increased the likelihood of relapse (Culkins et al., 2020; NIDA, 2018; Mitchell & Butz, 2019). Although correctional institutions worked in collaboration with probation and parole officers to provide much-needed support to those fighting addicting, it was difficult for the criminal justice system to improve the high rate of relapse considering the number of individuals released into the community after serving time (Culkins et al., 2020). One problem was the sheer number of parolees released into communities compared to the number of the probation and parole officers needed to ensure they received the support required for successful treatment for drug addiction post-incarceration (Bureau of Justice Statistics, 2019; Murphy, 2019). Incarceration allowed those with addictions to separate themselves from the realities of their lives and the pressures of survival and coping. Unfortunately, upon release from prison, those recovering from addiction and released back into their community, quickly became entrenched into their previous way of life (Simes, 2019).

Family dynamics changed due to the stigma of incarceration and addiction and no longer provided the social support critical to continued addiction recovery (Avery, 2019).

The expectations of release seldom matched the reality of reentrance, which created additional pressure and anxieties (Avery, 2019; Simes, 2019). The person might feel tempted to return to drug use to alleviate mental pressure as they tried to find safe housing and employment, which often resulted in relapse. Individuals previously enrolled in a rehabilitation program like MAT during incarceration were often assigned to a court-supervised out-patient treatment service within the community to reduce recidivism (Avery, 2019).

Background on Opioid as an Addictive Drug

Opioids are a classification of drugs commonly used to treat chronic pain, including OxyContin, oxycodone, and fentanyl (a synthetic derivative). Since 2017, researchers estimated that more than 72,000 people have died from opioid overdoses in the United States (Yerby, 2020). The Center for Disease Control (CDC) estimated that at least 130 people died from an opioid overdose every day, which was approximately 47,600 people. The number continued to rise in the 1990s, especially in the Midwestern states (Yerby, 2020). The first drug epidemic noted in the United States in the 1980s was crack. Today's epidemic, however, resulted from the over prescription of opioids as a means to treat chronic pain, usually post-surgery (Yerby, 2020).

Initially, pharmaceutical companies claimed their products were not addictive and offered significant incentives to physicians to encourage the use of their products. It was not until the use of opioids moved out of the city and into the suburbs, however, that governments paid attention to this growing problem (Dasgupta et al., 2018). Users, including parents, children, and family members with no prior criminal histories, increased in numbers (Yerby, 2020). More suburbanites showed up in emergency

hospitals across the country, and emergency calls increased, which placed a significant monetary burden on local economies. In the meantime, state governments invested in opioid treatment centers and education programs (Dasgupta et al., 2018). Many states also invested in the use of Narcan to reverse the effects of opioid overdoses, which required states to heavily invest in training for first responders. Despite these measures, however, the problems persisted (Yerby, 2020). Not every opioid user became addicted, but there were many reasons why people became addicted to drugs. The most common reason was the need to feel good and to experience a moment of pleasure, power, and self-confidence (Huhn et al., Tompkins, 2018; Stewart, 2019; Werner et al., 2019). People who suffered from mental issues, such as chronic depression, social anxiety, and stress used drugs simply to feel better and to function in a manner they viewed as socially acceptable in public and more intimate group settings (Huhn et al., 2018; Stewart, 2019; Werner et al., 2019). People also used drugs as a means to deal with the stress of daily life or a particular situation adversely affecting their lives (McHugh et al., 2020).

Social influences were another major factor in drug addiction, especially among teens and young adults. In high school, teens tended to follow the crowd to fit in, which sometimes included drug and or alcohol use. Friends often had the most influence over another's behavior and were a major resource for addictive drugs. Therefore, it became difficult to break the bonds of that friendship that provided a sense of connection and comfort (Herold & Søgaard, 2018). While the decision to use drugs was usually a voluntary decision, the decision to continue drug use implied the lack of ability to exert self-control, which was the earmark of addiction. Several theories attempted to explain the paradox between individuals who used drugs and those who did not use drugs, even

when faced with the same circumstances that may have prompted drug addiction, such as social influences and the need to fit in, even if the user was well aware of the risk of addiction (Lookatch et al., 2019).

Out-Patient Vs. Residency Drug Recovery Programs

More than 15,000 opioid addiction centers in the United States offered professional addiction recovery programs whether in residential facilities or out-patients (Jason et al., 2020). The cost of a residential program that included an intensive detoxification program and 24-hour supervision could, however, cost upwards of $2,000 per day compared to an out-patient program, which could cost upward of $250 to $800 per day (Miles et al., 2003). All opioid residential facilities usually offered the same type of recovery plans, but all residential programs required the patient to reside at the facility on an average of 30 to 90 days. Patients enrolled in a MAT program paid upwards of $14,112 per year. “Luxury” rehabilitation centers, often located in scenic areas, including beaches or lakefront, could cost upwards of $12,000 per month (Miles et al., 2003, p. 4). Many residential facilities had financing plans through a third-party lender who offered several affordable payment packages that the patient paid back in increments. Medicare covered both residential and in-patient (i.e., hospitalized) substance abuse treatments for adults 65 and over as long as the services are deemed “reasonable and necessary” (Department of Health and Human Services [DHHS], 2000). Medicare services provided to both residential or in-patient treatments under Part B include physicians, psychologists, social workers, and clinical nurses. Medicaid’s service for in-patients also included Screening Brief Intervention and Referral to Treatment (SBIRT) Services (DHHS, 2000).

This service aimed to identify substance abusers before the individual became dependent on their drug of choice (DHHS, 2000).

The SBIRT enabled the medical staff to screen and assist individuals who were not in a recovery program due to their refusal to admit having a substance abuse problem but found it increasingly difficult to deal with life issues, such as family, work, and financial issues. The SBIRT consisted of three steps (DHHS, 2000). The first component was a structured assessment or screening of the patient for risky behaviors using Medicare approved screening tools (i.e., survey assessments, drug tests) (Center for Medicare & Medicaid Service [CMMS], 2000). The second component was a brief intervention, which was usually an in-depth discussion with the patient that highlighted the risky behaviors identified in the initial screening and advised the patient on the best means to avoid addiction and the life consequences of substance dependency, such as the loss of family support and the loss of the ability to provide support for oneself. The third component was the referral for treatment for non-substance abuse (Beetham et al., 2020; CMMS, 2000).

To obtain approval for Medicaid payment, the SBIRT was administered by those licensed to perform medical assessments within that state, and the service provider had to be working with the State Scope of Practice Act, which defined the scope of practice in accordance with one's license on file of medical providers. For example, a nurse could not perform parts of the SBIRT that required a medical degree and license to practice in that state (Beetham et al., 2020; CMMS, 2000). Medicaid Part B also covered the cost of drugs used in a medical-assisted treatment program to treat opioid addictions, such as Suboxone. However, the use of MAT included a combination of other services and

provided individual or group counseling (Center for Medicare & Medicaid Service [CMMS], 2000). Medicare also required treatment use of a residential program for opioid abuse and provided a comfortable and safe environment for recovery and affordable payment options for service covered by most health insurers. Usually, when given an option, a substance abuser in the mid-to upper-income bracket opted for residential programs (CMMS, 2000). For low-income substance abusers, the option for treatment was usually limited to out-patient treatment programs due to cost and the lack of insurance payment options. For many low-income substance abusers, payment plans were not be a viable option for those released from prison and enrolled in a MAT program where treatment would continue in an out-patient setting. Those not covered under Medicare or other private insurance coverage, had the option of using Medicaid. Medicaid was the largest provider of health care for low-income individuals and families that was governed by the state, which meant coverage could vary by state. Coverage covered children under 19, pregnant women, those living with a disability, and a parent or adult who was caring for a child. In some states, individuals without dependents were eligible for coverage. Coverage would cover in-patient and out-patient hospital services. Some states offered intervention and short/long rehabilitation services, and family counseling. Although Medicare did not cover the cost of healthcare while incarcerated, an individual could apply for Medicaid in preparation for release to ensure the continuation of health care upon release. Continued health care is critical for those enrolled in drug rehabilitation while imprisoned and expected to continue treatment as part of their parole requirements (Felix et al., 2020).

In general, residential opioid rehabilitation programs had a higher recovery success rate compared to out-patient residential opioid rehabilitation programs. This was due to the controlled “safe” environment residential programs offered (Morales et al., 2019). It was more expensive, however, and was designed mainly for those experiencing serious, long-term addictions in which the individual may have had an uncontrollable need to seek out their drug of choice and take serious risks to obtain the drug (Bose, 2020; Morales et al., 2019). The individuals may have required larger and frequent doses of the drug and usually would lose interest in daily activities gradually, such as maintaining good hygiene practices and healthy food consumption. The individuals would have difficulty maintaining relationships, especially with those who did not engage in consuming their drug of choice, and would attempt to hide their drug consumption and expressed hostility toward those who attempted to address their drug problem (Aston & Cassidy, 2019; Morales et al., 2019).

However, as previously discussed, drug abuse did not necessarily equate to drug addiction. Some individuals who engaged in drug abuse could still function normally within their environment in regard to maintaining normal appearances. This was illustrated by those who were able to stop using to pass a drug test required by a potential employer or long enough to take and pass a drug test mandated as a condition of parole (Aston & Cassidy, 2019; Morales et al., 2019).

For many functional drug abusers who maintained a generally adaptive lifestyle and who fulfilled their obligations with health insurance to cover the cost, residential drug rehabilitation facilities were still the best option (Bose, 2020; Sant et al., 2020). Residential drug rehabilitation facilities developed a more sustained recovery process,

such as adopting the method of small steps, given that this phase could be tenuous for many individuals with opioid use disorder (Sant et al., 2020). Because cost was already covered by health insurance, residential drug rehabilitation facilities provided functional drug users better access to recovery from addiction (Bose, 2020).

Detoxification as Part of Recovery

Detoxification was an important component of drug recovery programs. Detoxification involved eliminating the effects of drugs or alcohol in a safe manner to minimize the symptoms of withdrawal (Dunbar et al., 2021). These symptoms were diverse, and included tremors, vomiting, insomnia, hallucinations, sweating, or depression (Dunbar et al., 2021). Detoxification was the first process in the recovery to remove the negative effects of the drugs.

As the first step towards recovery from drug or alcohol addiction, medical detoxification allowed individuals to have a less difficult experience during the emergence of withdrawal symptoms. Medical detoxification would not lead to the avoidance of all the symptoms associated with withdrawal, but these symptoms were alleviated with the use of medication (Levi-Minzi et al., 2017). Another benefit of medical detoxification was that the use of medication to relieve withdrawal symptoms from detoxification was provided in a safe environment (Levola et al., 2021).

In-patient Detoxification. In-patient detoxification had implications in psychosocial difficulties and treatment retention, underscoring the importance of providing effective care to patients (Levola et al., 2021). In-patient detoxification was characterized by the hospitalization of an alcohol or drug dependent individual into a residential or medical facility (Levola et al., 2021). Two weeks was the average length of

in-patient detoxification (Hogan et al., 2018). According to a study by Wu et al. (2018), the majority of in-patient drug detoxification involved patients who were male, between the ages of 35 and 64 years old, and were on Medicaid. Moreover, only 13% of those who were hospitalized for in-patient drug-detoxification received rehabilitation care, and only 14% were considered discharged against medical advice (Wu et al., 2018).

The most common diagnoses for those who were hospitalized for in-patient detoxification were opioid use disorder (75%) and non-addiction mental health disorders (48%) (Wu et al., 2018, p. 318). In terms of the nature of treatment, Wu et al. (2018) found those who were on Medicaid were more likely to receive detoxification and rehabilitation compared to those who were on private insurance, and who were more likely to receive detoxification only. In terms of treatment completion or retention, Levola et al. (2021) found that being younger than 35 years old, having an overall education history of 9 years and lower, being unemployed, using opioids and polysubstance, and more severe dependence were positively associated with incompletion of in-patient detoxification treatment. Hogan et al. (2018) also found that those who left in-patient detoxification treatment against medical advice typically included patients who lived nearby the facility, had criminal records, and expressed lower engagement with treatment.

Out-patient Detoxification. Out-patient or ambulatory detoxification involved the management of the withdrawal symptoms during the treatment for alcohol or drug addiction at a more flexible setting wherein hospitalizations were not necessary (Moore et al., 2019). Out-patient detoxification was particularly beneficial in increasing access to treatment for drug and alcohol addiction because of the flexibility of the treatment setting

(Brett et al., 2018). A detailed analysis of the case, however, including the history of abuse and physical health, was often necessary to determine whether an individual could be appropriately detoxified in an out-patient setting (Moore et al., 2019).

There was some evidence supporting the effectiveness of out-patient detoxification among individuals who sought treatment for drug or alcohol addiction (Brett et al., 2018; Ghodsian et al., 2018). Focusing on the effectiveness of telemedicine, Ghodsian et al. (2018) found this out-patient detoxification method was effective in terms of safety and efficacy without any medical or psychosocial complications. Brett et al. (2018) also found out-patient detoxification was beneficial to patients in terms of accessibility and having access to holistic and integrated treatment approaches for drug and alcohol addiction.

State Targeted Response to the Opioid Crisis

Different states developed different innovation models through their state targeted responses to address the opioid crisis (High et al., 2020). These state targeted responses to the opioid crisis were comprehensive and focused on different aspects of the drug problem, ranging from prevention and treatment to the sustainability of recovery efforts (Park & Otte, 2018; Scott et al., 2020; Shipton et al., 2018; Wagner et al., 2020). More specifically, most of the state targeted responses to the opioid crisis were focused on key issues, such as the prevention of opioid addiction, improvement in the access of treatment, reduction of unmet treatment needs, reduction of opioid overdose-related deaths, and the sustainability of recovery interventions (Park & Otte, 2018; Scott et al., 2020; Shipton et al., 2018; Wagner et al., 2020).

Prevention of Opioid Use Disorder

One of the goals of state targeted responses to the opioid crisis was to prevent opioid use disorder. Some of the strategies or interventions that were in place to prevent opioid addiction included a more mindful prescription of opioids to treat pain, education, and the development of safe medication disposal options (McCarty et al., 2018; Park & Otte, 2019; Shipton et al., 2018). The safe initiation and prescription of opioids to treat pain was one of the issues relevant to the prevention of opioid addiction (Reed, 2020; Shipton et al., 2018). For instance, advanced technology was developed to deter tampering of opioid-based products and to ensure the use of opioid for treatment was controlled and monitored (Park & Otte, 2019). Reed (2020) also highlighted the importance of evidence-based frameworks for effective and appropriate prescriptions of opioids for pain management.

Patient access to opioids was an important factor in the prevention of opioid abuse and addiction (Park & Otte, 2019; Reed, 2020). According to Park and Otte (2019), the best way to prevent opioid abuse was to eliminate the patients' access to opioids. The elimination of patient access to opioids entailed not prescribing patients opioids if they were not necessary or if its intended purpose already expired (Reed, 2020).

The prevention efforts that addressed opioid addiction emphasized the importance of education, both to the public and the prescribers (Davis et al., 2017; Eukel et al., 2019; McCarty et al., 2018; Reed, 2020). For instance, education efforts were primarily focused on the misuse of prescribing opioids to prevent inappropriate prescriptions to patients (Eukel et al., 2019). Academic outreach among pharmacists was also utilized to prevent

opioid abuse, underscoring the importance of education efforts to address the opioid crisis (Davis et al., 2017).

Another strategy that was utilized to prevent opioid addiction focused on the development of safe medication disposal options (Buffington et al., 2019; McCarty et al., 2018; Shafer et al., 2017). Both pharmacists and patients benefited from this type of education (Shafer et al., 2017). For instance, Buffington et al. (2019) emphasized the possible role of drug-take-back programs in order to minimize misuse of excess opioids.

The prevention of opioid abuse was an important component of exacerbating the opioid crisis in the United States. Some of these approaches that were intended to prevent opioid abuse included a more mindful prescription of opioids to treat pain, education, and the development of safe medication disposal options (McCarty et al., 2018; Park & Otte, 2018; Shipton et al., 2018). In the next section, the researcher will discuss the different approaches used to enhance access to treatment for opioid use disorder.

Access to Treatment

Access to treatment was found to be one of the barriers encountered by individuals with opioid use disorder (Scott et al., 2020). Hence, enhancing their access to treatment was one of the main goals of state targeted responses to address the opioid crisis (McGuire et al., 2020; Scott et al., 2020). Researchers such as McGuire et al. (2020), Mooney et al. (2020) and Scott et al. (2020) contended that community outreach, decision aids, and emergency department-based peer support improved access to treatment.

Community outreach programs were also utilized to bridge the gap in the access to treatment for opioid use disorder (Dayton et al., 2019; Scott et al., 2020). For instance,

Scott et al. (2020) found that community outreach programs were effective in helping individuals with opioid use disorder to seek treatment using medication-assisted interventions, which was proven to be particularly effective. Community outreach programs were also used to increase access to take-home naloxone (Dayton et al., 2019).

Another method that some states used to enhance access to treatment was through emergency department-based peer support (Liebling et al., 2020; McGuire et al., 2020). Liebling et al. (2020) found that hospital-based peer recovery support services for substance use disorder were effective in receiving referrals for treatment. Further, McGuire et al. (2020) reported that emergency department-based peer support showed some promise in linking medication to individuals with opioid use disorder.

The use of decision aids improved access to treatment for opioid use disorder (Mooney et al., 2020; Stacey et al., 2017). The rationale for decision aids was to help individuals with opioid addiction to gain access to information and resources that facilitated opportunities to seek treatment. Stacey et al. (2017) also reported that patient decision aids were used to empower patients to undergo screening in addition to seeking treatment for opioid decisions.

The expansion of Medicaid coverage was also used by states to improve access to medication-assisted treatment, which tended to be underutilized (Hinde et al., 2019; Wen et al., 2017). According to Wen et al. (2017), the expansion of Medicaid was particularly effective in enhancing access to buprenorphine, an effective Medication-Assisted Treatment for an opioid disorder. More specifically, Wen et al. (2017) found a 70% increase in prescriptions of buprenorphine prescriptions and a 50% increase in buprenorphine spending as a result of Medicaid coverage (p. 337).

In conclusion, one of the focuses of state targeted responses to the opioid crisis was the enhancement of the access to treatment. State targeted responses focused on outreach programs to increase access to treatment, decision aids, peer support, and expansion of Medicaid (Dayton et al., 2019; Hinde et al., 2019; Liebling et al., 2020; McGuire et al., 2020; Wen et al., 2017).

Reduction of Unmet Treatment Needs

Another key goal of state targeted responses to the opioid crisis was to reduce unmet treatment needs (Marotta et al., 2020; Miele et al., 2020). One approach to reducing unmet treatment needs was through the hub and spoke model (Brooklyn & Sigmon, 2017; Miele et al., 2020). The hub and spoke model focused on activities that intended to improve the amount and level of skills in prescribing medicine for an opioid use disorder and to enhance assistance for both in-person and online learning. The contents of the training included "buprenorphine waiver training and provider support, a practice facilitator program, Project ECHO sessions, webinars, clinical skills training, and regional learning collaboratives" (Miele et al., 2020, p. 20).

Another aspect of addressing the unmet treatment needs of people with opioid use disorder was to focus on those in the criminal justice system (Csete, 2019; Marotta et al., 2020). Individuals with opioid addiction or opioid use disorder in the criminal justice system were at risk for recidivism and relapse, which were influenced by their unmet treatment needs (Marotta et al., 2020). Csete (2019) also contended that public health advocacy was necessary to address the unmet treatment needs of individuals with opioid use disorder under the criminal justice system. Addressing unmet treatment needs of individuals with opioid use disorder was necessary to make state targeted responses to the

opioid crisis successful. This was particularly relevant in the criminal justice system wherein the needs of individuals with opioid use disorder were often unmet (Csete, 2019; Marotta et al., 2020).

Reduction of Opioid Overdose-Related Deaths

Another main goal of state targeted responses to address the opioid crisis was the reduction of opioid-related deaths. Different strategies were developed to reduce opioid overdose-related deaths, which included mobile outreach programs, overdose education, and naloxone distribution (Chen et al., 2020; Dahlem et al., 2020; Lambdin et al., 2020; McCarty et al., 2018; Wagner et al., 2020).

The use of mobile outreach programs was proposed to minimize opioid overdose-related deaths (Scherzer et al., 2020; Wagner et al., 2020). Scherzer et al. (2020) noted mobile outreach programs provided a 24-hour support group through chat, which was particularly helpful during times of critical moments. Supporting the use of mobile-based outreach programs, Wagner et al. (2020) found hospital staff had favorable attitudes toward using this type of intervention to prevent opioid related deaths. Wagner et al. (2020) also noted, however, that implementation and logistics challenges needed to be addressed carefully to ensure the use of mobile outreach programs for opioid use disorder was effective.

Overdose education, both directed at the staff and the patients, was one of the strategies that could be enhanced to improve efforts to reduce opioid overdose-related deaths (Chen et al., 2020; Dahlem et al., 2020; McCarty et al., 2018; Perri & Strike, 2020). Perri and Strike (2020) found overdose education improved both knowledge and self-efficacy, which led to overdose reversals. In addition to the importance of adequate

information regarding the role responsibilities during an overdose, Chen et al. (2020) also reported that education with regard to the provision of the take-home naloxone was particularly effective in reducing opioid overdose-related mortality. These research studies highlighted the importance of focusing on overdose education to reduce these preventable deaths.

Overdose education with Naloxone distribution was often considered the cornerstone of efforts to prevent or minimize opioid overdose-related deaths (Dahlem et al., 2020). The effective distribution of Naloxone was another component of strategies that focused on the prevention of opioid overdose-related deaths (Dahlem et al., 2020; Lambdin et al., 2020; McCarty et al., 2018). Naloxone was a drug used to counteract the effects of opioid overdose, underscoring its importance in the immediate occurrence of an opioid overdose (Lambdin et al., 2020; McCarty et al., 2018). The effective distribution of Naloxone was, therefore important to ensure there were timely medical responses to opioid overdose (Dahlem et al., 2020; Lambdin et al., 2020).

The increasing rate of opioid overdose-related deaths was a significant problem within the context of the opioid crisis. Strategies that were utilized by leaders to reduce opioid overdose-related mortality included overdose education, distribution of naloxone, and mobile outreach programs (Chen et al., 2020; Dahlem et al., 2020; Lambdin et al., 2020; McCarty et al., 2018; Wagner et al., 2020).

Sustainability of Recovery

Several approaches were introduced to improve the sustainability of the recovery of individuals with opioid use disorder. Some of these approaches focused on the development of emergency department-based peer support or coaching interventions and

community-based interventions (Harrison et al., 2020; McGuire et al., 2020; Watson et al., 2020). One strategy used by several state leaders in their state-targeted response to sustain the recovery of individuals with an opioid crisis was the emergency department-based peer support or coaching interventions (McGuire et al., 2020; Watson et al., 2020). The functions of emergency department-based peer support included "integration of peer support in emergency departments; alerting peers of eligible patients and making the patient aware of peer services; and connecting patients with recovery services" (McGuire et al., 2020, p. 82). McGuire et al. (2020) reported emergency department-based peer support showed some promise in linking recovery services to individuals with opioid use disorder. Focusing on the emergency department-based coaching interventions for recovery, Watson et al. (2020) found the implementation of the approach was pragmatic and could be replicated in other states.

Another strategy that was implemented to effectively sustain the recovery of individuals with opioid use disorder was community-based programs that focused on abstinence-based recovery (Harrison et al., 2020; Truong et al., 2019). Community-based programs were a source of support during critical times during the recovery of individuals with opioid use disorder (Harrison et al., 2020). Community-based programs were also instrumental in the improvement of access to maintenance medicine, which was particularly important for the sustained recovery of individuals with opioid use disorder (Truong et al., 2019).

To summarize, one of the goals of state targeted response to the opioid crisis was to develop interventions that would lead to the sustainment of recovery of individuals with opioid use disorder. Some of these approaches that enhanced recovery efforts

included the development of emergency department-based peer support or coaching interventions and community-based programs (Harrison et al., 2020; Truong et al., 2019; Watson et al., 2020).

Implementation Barriers of State Targeted Response

State-targeted responses to the opioid crisis hinged on three main areas: prevention, treatment, and recovery from opioid use disorder (High et al., 2020). In the following subsections, the researcher focused on the different barriers that affected the implementation of state targeted responses to the opioid crisis.

Barriers in the Prevention of Opioid Addiction

The barriers in the prevention of opioid use disorder included different factors ranging from lack of education regarding opioid use and prescription and existing laws and legislations. These barriers posed problems in the successful resolution of the opioid crisis, including state-targeted response programs (Dahlem et al., 2020; McCarty et al., 2018). Education played an important role in the opioid crisis, and more specifically, inadequate education with the prescription and use of opioids led to the development of opioid addiction (Dahlem et al., 2020). Existing laws and legislations concerning prescription practices also served as potential barriers and contributed to the misuse (Hodge et al., 2017; McCarty et al., 2018).

Barriers in the Treatment of Opioid

There were several barriers to the treatment of opioid use disorder, which affected the ability of leaders to accomplish success in state-targeted responses to the opioid crisis. The barriers for treatment intervention were complex and based on different factors, compromising the efforts of state-targeted responses to the opioid crisis (Germack, 2020).

The common treatment barriers included ineffective treatment systems, the complexity of the admission process, and lack of funding for the implementation of interventions (Borda et al., 2021; Germack, 2020; Levin & Cates-Wessel, 2018; Reif et al., 2020).

The treatment system for opioid use disorder continued to be a barrier because of its ineffectiveness (Levin & Cates-Wessel, 2018). More specifically, many health care providers were ill-equipped in providing empirically-supported treatment interventions to individuals with opioid use disorder. Another systemic factor that affected treatment was the restrictions placed among Advanced Practice Registered Nurses (APRNs) to provide prescription medication for treatment of an opioid use disorder (Levin & Cates-Wessel, 2018).

The complex nature of the admission process was found to be a treatment barrier for opioid use disorder (Borda et al., 2021). The decision process was described as complicated for many patients. This complexity made seeking treatment difficult and challenging for some individuals who needed access to effective treatment and interventions (Mooney et al., 2020).

Another barrier to treatment was the underutilization of medication-assisted approaches for opioid use disorder (Hinde et al., 2019; Valenstein-Mah et al., 2018). Individuals with opioid use disorder did not utilize medication-assisted treatment even though the medication was available (Valenstein-Mah et al., 2018). Another barrier that limited the effectiveness of state-targeted responses to the opioid crisis was the lack of funding for treatment. The federal Opioid State Targeted Response (Opioid STR) grants were responsible for providing programs across the states (Reif et al., 2020). Financial

resources were important to implement these state-directed programs and policies (High et al., 2020).

Summary

The purpose of this qualitative case study was to explore the current State Targeted Response (STR) Program in a Midwest recovery program that addressed increases in opioid abuse and barriers to recovery. In this chapter, the researcher focused on several aspects of the literature that are central to the research problem, such as previous research studies on the different models for the conceptualization of addiction, background on opioid use disorder, integrative treatment approaches, the difference between residential and outpatient treatment approaches, state-targeted responses on the opioid crisis, and barriers to the resolution of the opioid crisis.

From the literature review, it became evident that social influence and support were major aspects of drug addiction and recovery. Moreover, many factors, such as education, gender, or race affected the vulnerability to drug addiction. Furthermore, the prison service environment was not supportive of drug addiction recovery and relapse prevention. The researcher discussed the effectiveness of state targeted response to the opioid crisis based on aspects, such as accessibility, suitability to client's needs, and prevention of opioid use in the first place.

In the next chapter, the researcher presented the study's research methodology, including the research plan and procedure to implement the goals and objectives of the study. Further, the researcher discussed the rationale for the methodological design and the sampling selection. The chapter also included information about the ethical procedure and trustworthiness of the current research study.

Chapter Three: Methodology

Introduction

The qualitative case study explored the current State Targeted Response (STR) Program in an urban city in the Midwest in relation to the increase in opioid abuse and barriers in recovery. The sections in this chapter included the role of the researcher, overview of the chosen methodology and instrumentation, chosen procedures for recruitment and data collection, data analysis, ethical considerations, and a summary. The key phenomena addressed were the opioid crisis, state-targeted response interventions to tackle the opioid addiction, and barriers preventing the successful implementation of state targeted responses, such as budget, legislative issues, protracted hiring, and procurement problems (High et al., 2020). Moreover, prevention, treatment and recovery barriers were also addressed.

Research Design and Approach

The current study followed a qualitative methodological approach. One of the key strengths of using a qualitative approach was that issues could be explored in depth and in detail, which allowed for powerful and compelling data to emerge, while data emerging from quantitative data could be limiting and restrictive (Anderson, 2010). The quantitative research methodology provided the scope to quantify large data and allows for the conclusions to be generalized (Anderson, 2010). However, this was not suitable for the current study, as the goal was to provide an unrestricted and explorative environment for the participants to express freely, thus creating an opportunity for new themes to emerge.

The research study also included a case study design. The rationale behind this choice was the flexibility it offered as the case study research design was not constrained

by a specific theoretical principle approach to study a complex phenomenon (Yazan, 2015). The goal of the study was to adopt the explanatory, flexible, participant-centered approach, which rendered the case study research design an appropriate choice. Moreover, the case study design offered an opportunity for the natural occurrence of complex processes in bounded groups and was useful for developing an understanding of these processes (Yazan, 2015).

The role of the researcher in the current study was that of an observer. The focus of the current study was on the examination of a complex phenomenon in its natural environment without manipulating the context (Yazan, 2015). The researcher conducted the open-ended interview questions, focus groups, and secondary data collection, but resorted to observation only, allowing the subjects to explore the topic at hand. The researcher oversaw the data collection process and provided instructions but did not have a supervisory role in the process. No other ethical issues arose that could have affected the trustworthiness and validity of the results of the study.

Research Questions

The research questions of the study were the following:

Research Question 1: How do substance abuse counselors detect and address potential barriers, if any, to addiction recovery?

Research Question 2: What do substance abuse counselors view as improvements within the STR to reduce relapses?

Research Question 3: How do counselors adequately address the social aspects of addiction?

Research Question 4: How do counselors adequately address the factors influencing addiction relapse?

Research Question 5: How do counselors collect feedback from clients concerning the effectiveness of treatment?

Setting, Population, and Sample

The chosen sample size for the proposed study was a minimum of six and a maximum of 10 participants. The focus group size was limited to four to five participants. The rationale behind the maximum was to allow for an in-depth analysis and exploration of the interviews and focus groups discussions. Having too many participants in a focus group and interviews would be too challenging to manage for the research, and some participants would have had less of an opportunity to contribute to the discussion if the focus group was too large (Andrade, 2020). Moreover, saturation of data occurred when no new information was obtained from the generated data during the data analysis (Weller et al., 2018). Saturation of data was more likely to be reached in smaller samples (within the 10-participant limit) as topics were discussed in detail, which would not be possible if the sample size was larger than that (Weller et al., 2018). A sample size that is too small would result in a limited perspective and a potential risk of one-sidedness (Andrade, 2020).

Participants selected for the proposed study were counselors. Each counselor counseled at least one client that relapsed 3 months after completing the out-patient program and held a state required licensure and/or certification(s) as drug addiction counselors. The rationale behind choosing these participants was to allow the researcher to discover first-hand information from counselors of the service users and their

experiences with counseling individuals on opioid addiction issues and reasons for relapses. The sampling strategy chosen for the current study was purposive sampling. Purposive sampling was when the researcher selected the participants based on the purpose of the study, and from a specific population (Serra et al., 2018). The rationale behind this sampling strategy was to recruit participants who could provide detailed information about the phenomenon of success or failure of out-patient rehabilitation (Luciani et al., 2019). The goal of the study was to identify and address the issues that played a significant role in the long-term success or failure of out-patient rehabilitation, and interviews with the counselors provided first-hand insight into this issue.

All participants selected for this study were over the age of 17, which was the consenting age in the state of Missouri. All of the participants chosen for the study were either native or fluent in the English language to allow for a transparent analysis of the conversation without the risk of an English word being misinterpreted or used in an unintended context, which could potentially impact the quality of the data. Participants were compensated to take part in the study and received a gift card of value of $25.00. The researcher issued these vouchers subject to a successful completion of the study by the participants.

Participants were recruited through a letter requesting permission to conduct the research to the Chief Compliance and Ethics Office, with a follow-up telephone call to answer any questions the CCEO may have had. The participant list was narrowed down using the following criteria: counselors who have counseled first time clients returning to the program after 3 months of program completion. Secondary data was used to gather demographic information on clients that returned to the program within 3 months of

completing an out-patient program. The information consisted of gender, age, and environmental parameters, such as living conditions. This information was gathered by the researcher from the facility data bank.

Instrumentation and Materials

The current study consisted of an open-ended interview, focus group, and secondary data collected on the patients. The rationale for choosing an open-ended interview approach was to allow the participants to share more in-depth responses, which, in turn, helped to generate richer data. Instruments that were used for the data collection process consisted of an interview protocol, focus group protocol, secondary data collection form, and an audio tape. All the instruments apart from the audio tape were designed by the researcher. The secondary data instruments were sourced from peer-reviewed studies only, thus ensuring the reputability of the instrument. Focus group protocol was used to measure the counselors' perception of the STR program and the perceived improvements to the program. Next, the interview protocol was used to detect and address the potential barriers to recovery and any perceived improvements to reduce relapses. Lastly, secondary data on patients' gender, age, and environmental parameters, such as living conditions were collected from the facility's data bank.

The researcher ensured the obtained secondary protocols/instrumentation met the requirements of the current study; this was ensured through obtaining the instruments from studies relevant to the field of rehabilitation, addiction, and recovery. Moreover, the protocols and instruments were rewritten by the researcher to ensure they were culturally appropriate and fit the context of the current study.

Case Study Participants

The counselors that took part in the current study worked with individuals suffering from opioid addiction. The individuals that sought counseling for opioid addiction were typically individuals suffering from chronic pain who needed medication to alleviate pain, which was also the topic discussed with the counselors (CDC, 2018). Opioids, however, were highly addictive, which caused many patients to become over-reliant on the drugs, and their counselors. (Scanlon & Hollenbeak, 2019). This means that the counselors were treating not only the opioid addiction, but also problems, such as pain and dependency relationship with drugs. Each counselor counseled at least one client that relapsed 3 months after completing the out-patient program and held a state required licensure and/or certification(s) as drug addiction counselors.

Data Collection

The data collection process took place in three separate segments: A total of 6 participants participated in one-on-one interviews, 4 of 6 participants participated in the focus group, and secondary data was collected on patients from the facility data bank. All the data were collected by the researcher. Data collection took place at the out-patient clinic in an urban city in the Midwest. The facility was a comprehensive behavioral health non-profit organization that provided substance abuse treatment, prevention, and mental health services.

The researcher used that facility for the interviews and focus group to ensure the privacy and confidentiality of the participants. Data collection took place across several weeks, as the interviews and focus group were scheduled around the counselors' work and family obligations. One-on-one interviews took 33 to 55 minutes to complete, and

focus group activities took 60 to 75 minutes to complete. Interviews and focus group were recorded on the audio tape and remained stored on the researcher's password-protected laptop. All recordings were deleted after use. The researcher took notes from the field observations and only recorded key observations that were relevant to the research questions.

After the study was completed, the researcher collected secondary data on the patients treated by the counselors and gathered data on their gender, age, and environmental parameters, such as living conditions. Each participant received a debrief document advising them of data confidentiality, data protection, purposes of the study, and contact details for the researchers. In an event where there were not enough participants, or last-minute cancellations, the researcher intended on following the same recruitment strategy. In order to ensure that no delays were encountered, all of the interviews and field observations took place in advance to help manage time restraints. Participants were advised that they could request to have their data removed from the study at any time after the study was completed.

Data Analysis

Data was analyzed using thematic analysis, and the data analysis tool used in the study was the NVivo qualitative software. Thematic analysis was a method of data analysis typically used for text data and interview transcripts (Nowell et al., 2017). Moreover, this type of analysis focused on identifying common emerging themes from text, interviews or observations, which were ideas that occurred repeatedly (Nowell et al., 2017). Braun and Clarke (2006) provided a six-step framework for carrying out thematic analysis, which was used by the researcher. First, the researcher familiarized themselves

with the data collected. Next, the researcher generated initial codes to label the data and searched for emerging themes from the codes. A word cloud displayed enabled the researcher to view which words were most frequently used during the one-on-one interviews. Afterwards, the researcher reviewed the themes and defined them before concluding with a final write-up of the analysis (Braun & Clarke, 2006).

The focus of the current study was to explore the potential barriers to recovery, perceived improvements to the rehabilitation to reduce relapses, counselors' perceptions of the program, and perceived improvements to the program according to the counselors. As all of the data were collected through interviews and focus groups, thematic analysis was the most appropriate method to identify emerging themes and ideas (Braun & Clarke, 2006). All discrepant cases (i.e., themes that disagreed/negated the other themes) were included in the analysis to ensure an accurate and factual analysis of the data.

In research, Renz et al. (2018) argued triangulation was a method of combining different research methods in one study. The researcher adopted a triangulation strategy to ensure the credibility and dependability of the data that was obtained through interviews, focus groups, and secondary data collection. To ensure transferability of the findings, the researcher recruited individuals who were rehabilitation counselors, both men and women. This ensured that the data represented both perspectives. Lastly, the researcher ensured that intra-coder reliability of the findings was maintained through maintaining consistency of the designated codes in the Nvivo software and in the analysis process.

Ethical Protection of the Participants

There were several ethical procedures to consider in order to ensure safety, confidentiality, privacy, and dignity of participants in the current study. In order to ensure that the study met the ethical requirements, an IRB application was submitted. A sample IRB application was obtained from the Institutional Review Board (IRB) Office for Research website. The IRB application is attached in the Appendix H.

In order to gain access to the participants, the researcher carried out a direct recruitment by submitting a request letter to the CCEO of the out-patient clinic facility and narrowed down the list of participants to counselors who had counseled first-time service users who were released into the program within the first 3 months after the completion.

To ensure protection of the participants, the researcher remained neutral in their questioning and did not discuss the topics with which the participant was uncomfortable discussing. The style of the study was exploratory and without narrative to allow the participants to express themselves and share as much as they felt comfortable sharing. No specific message or idea was imposed upon the participants to allow for a free discussion with no judgement from the researcher. Moreover, some of the participants experienced health-related issues. The researcher did not put the participants in any situations that could potentially cause harm or put the lives of the participants at risk.

Ethical concerns of data confidentiality and privacy arose as all of the interviews and focus groups were recorded using an audio tape by the researcher. In order to address these concerns, the researcher advised the participants they would record the interviews and focus groups and asked for the participants' written permission to allow the

researcher to use that data. Moreover, the researcher was obliged to delete all recordings after the project was completed. The researcher ensured all individuals remained anonymous in their analysis by using the numbering system (A, B, C, etc.). All recordings were kept on a password-protected laptop designated solely for the purpose of this academic research.

Another ethical concern arose if a participant decided to withdraw their data from the study or refused to take part in one of the segments of the study. All participants voluntarily agreed to take part in the study and were not pressurized to take part, and thus were protected under voluntariness (Biros, 2018). In order to address this, the researcher made sure to clearly explain the participants' requirements for the study and to ask for written permission. In the case that a participant withdrew their data, the researcher disposed of the data immediately and securely and did not use that data in their final analysis.

All participants selected for this study had the capacity to give their written consent to take part in the study, to withdraw from the study, and to ask to receive a copy of the recording and written data. The rationale behind this was to ensure that all participants were able to provide an honest account of their experiences at the rehabilitation program. Any individuals who were unable to consent may not have been able to provide such an account.

Another risk that arose during the study involved the use of counselor information on a specific program that may have had an adverse effect on the institution in general. Secondary data involving client demographics was also a risk; this included unique client identifiers. There was a risk of participating counselors inadvertently exposing vital client

or institutional information in response to certain questions in one-on-one interviews or during focus group discussions. To manage these risks, all information gathered by the researchers was confidential, stored in the secured location, and shredded before disposal in accordance with school policy. All data that seemed insignificant to the study was destroyed at the end of each session. No names of unique identifiers were used in the final reporting.

Lastly, the researcher was the only person with access to the recordings and the written data. Participants were allowed to ask to see a copy of their data from the researcher. All data was treated in a confidential manner and all recordings were stored on a password-protected laptop. Notes from interviews and focus groups were typed up and saved on the password-protected laptop, and all physical notes were safely disposed of, not to be retrieved again.

Limitations

There were several limitations in the current study that should be mentioned. The participants in the study were confined to addiction counselors who have counseled at least one client who has relapsed 3 months after completing the out-patient treatment program and possessed a state required licensure and/or certification as a drug addiction counselor. The exclusion of other stakeholders, such as state leaders, intervention designers, and other health care professionals meant the findings may not have been as comprehensive as intended. Another limitation of this study is that the sample primarily consisted of 74.3% White male participants, which meant that the findings may not have been reflective of diverse views and perspectives across different gender and racial backgrounds.

Moreover, the location of this research study was confined to a single site, which was the state-targeted response program in an urban city in the Midwest. The results of the research study may not be generalizable or applicable to other state targeted response programs in the Midwest and other regions of the United States. Further, the sources of data for this study came from one-on-one interviews, focus groups, and secondary data. All these data sources were qualitative in nature, which meant that all data was in narrative format and could not be quantified or statistically analyzed (Silverman, 2020). No quantitative data was collected in this research study.

Lastly, the study design was a qualitative case study research design. The selection of this research design was a limitation because cause and effect conclusions could not be made. Instead, all the findings were based on the perceptions and experiences of counselors and their clients who have recovered from opioid use disorder. Thus, all the findings were subjective in nature.

Summary

In the current chapter, the researcher presented the purpose of the study and the research questions. Next, the researcher provided an overview of the chosen methodology, instrumentation, procedures for recruitment, participation, and data collection. Furthermore, the researcher provided a description of the data analysis method and data analysis tools for the study. The researcher concluded the chapter with ethical consideration of the proposed study as well as their plan to address these issues.

Chapter Four: Research Findings and Data Analysis Results

The researcher sought to investigate the State Targeted Response (STR) Program in a Midwest recovery program that addresses increases in opioid abuse and barriers to recovery. Chapter Four included a presentation of the findings derived from the analysis of data gathered from the semi-structured interviews. In the first section of the chapter, the researcher provided descriptive information on the study participants, and involvement in the data collection activities (i.e., interviews). Next, the researcher provided a description of the data analysis conducted for the study. Lastly, the researcher concluded the chapter with a summary.

Data Collection

A total of six participants completed this study. These six participants completed the interviews. Four of the interview participants went on to participate in a focus group discussion as well. Each interview and the focus group discussion were recorded and transcribed. All transcripts were then uploaded to NVivo 12 Pro for organization and analysis. The data was organized by participant, and each participant was given a pseudonym, and all had specific characteristics (see Table 1).

Table 1

Focus Group Participant Characteristics

Participant	Position	Years of experience	Credentials
1	Licensed clinical social worker	4	Drug addiction counselor Master's degree
2	Drug addiction counselor/licensed clinical social worker	5	Drug addiction counselor Master's degree Supervision
3	Drug addiction counselor/licensed professional counselor	6	Master's degree Supervision
4	Drug addiction counselor/licensed professional counselor	1 year, 4 months	Master's degree

In addition to having data on participants in the qualitative study, information about 568 program clients was also collected. Table 2 included the characteristics of the clients.

Table 2

Client Characteristics

	Average	Range
Age (years)	34.7	20-61
Gender (%Male)	75.53	
Employment status		
Not In Workforce-Other	54.4	
Employed – Part Time (<35 hrs/wk)	9.3	
Employed – Full Time(35+hrs/wk)	13.6	
Unemployed – sought last 30 or on layoff	12.2	
Unknown (invalid for ADA prog assign)	8.98	
Race		
White, Not Hispanic	74.3	
Black, Not Hispanic	21.8	
Unknown	1.8	
Middle Eastern or North African	0.35	
Biracial	1.06	
Spanish American	0.35	
Self-Report Psych at Admission (% yes)	50.9	

Data Analysis and Results

Transcripts from the one-on-one interviews and the focus group discussion were read and analyzed thoroughly and entered in the software, Nvivo 12, for analysis.

Thematic analysis of the transcripts was conducted to find and analyze potential themes regarding potential barriers to recovery, perceived improvements to the rehabilitation to reduce relapses, counselors' perceptions of the program, and perceived improvements to the program according to the counselors. The researcher used Braun and Clarke's (2006) six-step framework for thematic analysis. First, the researcher became familiarized with the data collected. Next, the researcher generated initial codes to label the data and searched for emerging themes from the codes. Afterwards, the researcher reviewed the themes and defined them before concluding with a final write-up of the analysis (Braun & Clarke, 2006). The answers to the interview and focus group discussion questions as well as the focus group notes from the meeting were thematically analyzed using NVivo 12 software and aligned with the research questions.

Figure 1.

Word Cloud

Note. The size of the word increases with the frequency with which it was used in interviews.

Reliability and Validity

Credibility and dependability were assured through an objective data collection process and documented every step of the research. The researcher also adopted a triangulation strategy to ensure the credibility and dependability of the data obtained through interviews, focus groups, and secondary data collection. Further, transferability was assured in the present study in two ways. First, the researcher recruited individuals, both men and women, who were rehabilitation counselors; and ensured the data represented both perspectives. In addition, a thick description of a phenomenon, derived from thorough data collection and analysis, was used as a strategy to enable transferability. References were made to provide a description of the setting and participants of the study as well as to provide a description of the findings with adequate evidence presented in the form of quotes from participant interviews, field notes, and documents.

The study aimed to explore the potential barriers to recovery, perceived improvements to the rehabilitation to reduce relapses, counselors' perceptions of the program, and perceived improvements to the program according to the counselors. As each of the data was collected through interviews and focus groups, thematic analysis was the most appropriate method to identify emerging themes and ideas (Braun & Clarke, 2006). All discrepant cases (i.e., themes that disagreed/negated the other themes) were included in the analysis to ensure an accurate and factual analysis of the data.

There were six themes that arose from this iterative, qualitative analysis: (1) assessments, (2) addressing barriers, (3) suggestions for improvement, (4) addressing

social aspects, (5) addiction relapse, and (6) program effectiveness. Each theme encompassed several subthemes and codes.

The first theme, assessments, was composed of two subthemes: assessing need and biopsychosocial assessment. These subthemes developed from participants' rich and varied responses to the questions about how counselors detected and addressed potential barriers to addiction recovery. Participants detailed the methods used to detect the barriers.

The second theme, addressing barriers, did not have any subthemes, but was composed of participants' descriptions of methods used to address barriers. These descriptions related to understanding barriers that clients faced and the use of motivational interviewing to address the barriers.

The third theme, suggestions for improvement, was composed of three subthemes: program components, infrastructure, and no changes. The third theme related to participants' descriptions of how the recovery programs could be improved. The subthemes arose from participants' responses to questions regarding whether the participant perceived any need for improvements within the program to reduce relapses.

The fourth theme, social aspects, was composed of three subthemes: culturally sensitive approach, addressing social aspect of addiction, and limit biases. This theme covered ideas conveying the participants' beliefs regarding how social and cultural factors were considered in the program's approach to recovery. Participants described multiple approaches taken to incorporate social and cultural aspects into the program.

The fifth theme, addiction relapse, was composed of two subthemes: perception of clients who relapsed and counseling returning clients, detailing information about

participants' experiences regarding working with returning clients. Participants conveyed personal beliefs and perceptions about the individuals and shared individual approaches for counseling.

The sixth and final theme, program effectiveness, encompassed participant descriptions on their perceptions regarding the success of the program. Program effectiveness also included information from participants regarding the most important aspects of the program and included opinions about what was lacking from the program that reduced effectiveness.

Research question 1. How do substance abuse counselors detect and address potential barriers to addiction recovery?

Assessments

One major theme was assessments, which exposed participants' reports of methods they used to detect potential barriers to addiction recovery. This theme was composed of two subthemes: assessing need and biopsychosocial assessment. These subthemes represented the multiple methods that counselors used for detection. All subthemes and examples of quotes that motivated these subthemes were provided in the following sections.

Assessing need.

All 6 interview participants provided descriptions of how they assessed the needs of their clients. For example, Participant 3 descr'bed, "I've been working with the help (sic) would start off by asking clients what their biggest need is. Whether it be about the housing, be it feeding, shelter at the end of the day we can take them in." Similarly,

Participant 1 said, “Me and my staff, we interact with clients and a lot of clients tell me what their needs and goals are.” Participant 5 also commented:

> Well, from a practical standpoint we do an assessment when they come here for services. S’, there's not much work on our end as far as initial detection, as far as screening if there is a concern, beca’se they're coming to our facility beca’se they've already determined that there is a concern. At that point then we had determined through the assessment, what is the nature of the concern, and to what extent the substance use is a concern. For example, is it mild substance abuse, or dependency, versus moderate, versus severe?

Participant 6 also stated simply, “Usua’ly they're detected by first assessing the client, asking questions, asking about their needs and their goals, what their plans are, w’at they're lacking.”

These participants conveyed the importance of directly asking clients what their needs were, as this process helped to reduce some barriers to recovery.

Biopsychosocial assessment.

Two of the six interview participants described using a biopsychosocial assessment to help address potential client barriers. Participant 4 noted:

> They receive a comprehensive bio-psychosocial assessment…which incl’des, it's not limited to the DLA 20, which is the daily living activities 20, which is sort of the benchmark score across the nation everybody uses to determine where are areas of need and wh’re they're successful.

Participant 2 also referenced a similar type of assessment and talked through the thought process of the client:

> If you come in and you think ’hat you're just going to fix everything for this per’on, you're not really finding out what they think needs to be changed. Someone could sit in front of me and’say, ‘I'm homeles’. I don't have food.’ And housing might not be a priority for them, but I might view it as like, ‘Oh, they need somewhere to stay.’ That might not be a priority for them, their first priority might be food.

In addition to the assessments described in qualitative interviews, participants also shared some information conveyed by assessments, such as the MAT medication and substances used. This information is presented in Table 3.

Table 3

Client Characteristics

	Percent Used
MAT Medication	
Oral Naltrexone	2.7
Suboxone	50.5
Subutex	26.5
Vivitrol	15.8
Substance	
Alcohol	1.9
Fentanyl	32.8
Glutethimide	0.5
Heroin	59.5
Hydrocodone	1.8
Marijuana/Hashish/THC	0.4
Methamphetamine/Speed	0.4
Other cocaine	0.4
Other opiates and synthetics	0.9
Oxycodone	1.6

In summary, the assessment theme was frequently referenced by participants. The assessment theme addressed the first question by demonstrating the actions

participants took to detect potential barriers for clients. The assessment theme was composed of several examples of types of assessments.

Addressing Barriers

Another major theme was addressing barriers, which exposed participants' descriptions of the methods used to address client barriers that would interfere with recovery. Addressing barriers represented the factors that participants identified as important for dealing with barriers. Examples of quotes that motivated this theme were provided in the following section.

Three of the six interview participants provided descriptions of how they attempted to address barriers for their clients. Two of these participants mentioned they tried first to understand barriers clients faced. For example, Participant 6 stated:

> A lot of the barriers include transportation problems, homelessness, some of them have mental health issues. And so, we usually try to provide them, as far as addressing them, we provide them with bus tickets, which is provided by, I think it is the STR program. Resources for housing, shelter, the OSUD, I think it funds. Like Sober Living Housing helps them to find food resources and help us to... Well, n'w they don't really help us with this, but we do. We just try to engage them with other agencies that could provide them with mental health help and medication.

Similarly, Participant 2 noted, "Some of those barriers, they just might not have access to some of those services. So, we eliminate a lot of times a big barrier for people with just having the services." These participants were aware of some obstacles their clients faced and understood the importance of identifying and addressing these barriers.

In addition, Participant 1 shared a different method they used to address barriers. This participant reported, “By using motivation interviews, a lot of clients would tell me what their barriers are ’nd then we'll go from there.” In summary, the addressing barriers theme included methods used to minimize barriers that interfered with clients’ successes in recovery. This theme addressed the first question by further showing the methods used to address barriers and included examples of how participants approached these types of problems.

Research question 2. How do substance abuse counselors see any need for improvements within the STR to reduce relapses?

Suggestions for Improvement

The suggestions for improvement theme revealed that counselors to see a need for improvements and included information about how participants perceived the programs could be enhanced. Suggestions for improvement included subthemes related to the types of changes participants thought would help. The subthemes related to this theme were program components, infrastructure, and no changes. The program components and infrastructure subthemes and examples of quotes that motivated these subthemes were provided in the following sections. The no changes subtheme included responses from two participants who did not feel that any changes to the program were currently needed.

Program components

All participants reported on specific aspects of the program that could be changed. Five of the six participants remarked that the program design could be re-evaluated. For example, Participant 2 said:

> I would definitely like to see the housing opportunities expanded and even further than that, having different levels of that housing aspect. I think folks are all grouped into one house and sometimes that can be a negative for people where maybe people who are six months sober, have folks that are really still, maybe actively struggling with using and stuff.

In addition, Participant 5 shared:

> Changing definitely with the way we run assess'ents. They're pretty much impromptu now, so we go through this epic program for the opioid clients, so they are told to come to Dunnica in the morning. And then at some point during t'e day they're going to get an assessment and see a provi'er, but it's not scheduled, and I wish they were scheduled. It would make it easier on me to plan accordingly, 'o I wouldn't have to block off certain period of time where these new assessment people that come in for assessments, may or may not show up. So, what I do to try to mitigate for that and so as the other therapist, is we block off time, but that also takes away time from some of the clients I could be seei'g, so that's frustrating.

Participant 6 reported, "I think it (sic) change would be a good 'dea, I don't know if that would be feasible or possible, where they would include families instead of just the individual because a lot of times the one individual just totally disrupts the family."

Another type of program component that several participants thought could be adjusted was the inclusion criteria for the program. Participants reported that they felt some criteria were too restrictive for the program, limiting the number of people who could benefit from it. For example, a focus group participant suggested:

> I would also like to see housing expand more to include as many people as possible' Like what's already been said, I think housing is really key to them being able to stay clean, not just stay clean but remain clean.

This sentiment was shared by all participants in the focus group discussion. Similarly, Participant 4 identified another criterion that could be changed:

> Well, I think the stipulations for the program include, they preclude people who have Medicaid. And although Medicaid will pay for MAT medications, I think that sometime' there isn't a lot of housing widely available for folks with Medicaid, 'nless they're a certain age or they have a level of disability. And so that is a factor that would prevent somebody from being enrolled in STR.

The participants felt that having a more open process for enrolling people in the program would be beneficial for potential clients.

Infrastructure

Many participants described how various components of infrastructure could be improved. Four participants commented that an increase in funding and expansion of the program would be useful. A participant from the focus group stated:

> I also think just expanding that housing in general to have more housing and also just to go along with the basic needs being met. Maybe having vouchers for groceries, for clothes, kind of those other basic needs that sometimes go along with people needing housing. They often need other necessities, as well, so expanding the funding for that.

Two other focus group participants echoed this statement, supporting the need for additional housing. Participant 2 of 4 also described that housing was important to

expand and added, “I think expanding access with transportation, I would be interested in that expansion, like giving gas cards to people who have their own cars.” Participant 4 of 4 also stated:

> So, I would like increased funding for more staffing’because we're understaffed’and we can't address the needs as quickly and as often as we need to for a lot of our clients, because in this area of South’City there's a lot of clients that have severe mental health needs.

Another aspect of these programs participants thought could be improved was staff training. Additional training in areas like bias, cultural competence, assessments, and therapy were suggested by two participants. For example, Participant 1 stated:

> I think I looked at this and my thing was, I think about this more. I think I was going to say bias people being biased, because I think sometimes peers and counselors pick and choose who they want to help.

Similarly, Participant 5 shared:

> I think we need more training around cultural compe’ency, that's my main one. I would like that to be done through in-person training, not just online training ’uys. I don't k’ow if that's feasible right now, due to the COVID-19 situation’ That that's the biggest ch’nge. I can't think of anything else that I would want to change at this time.

These participants identified the shortcomings of their current training and believed that additional training in specific areas could strengthen their programs.

In summary, the suggestions for improvement theme had many references, and most participants contributed opinions. This theme addressed the second research

question by describing the ideas that participants had for enhancing their programs. Suggestions included increasing funding, adding training for staff, changing some criteria for inclusion in the program, and adapting some of the existing program practices.

Research question 3. How do counselors address the social aspects of addiction adequately? The social aspects theme included information about participants' descriptions of how they addressed social aspects of addiction. The theme included subthemes related to the methods employed to address these social aspects of addiction, specifically limit bias, culturally sensitive approach, and addressing social aspects of addiction, which highlighted the diversity of factors that were involved in taking a socially aware approach to counseling. All subthemes and examples of quotes were provided in the following sections.

Limit bias. A few participants (n=3) reported limiting their own biases was crucial to adequately serving clients. For example, Participant 3 shared, "I trust you and I want you to tell me truth and are open minded…I guess just being open minded." Similarly, Participant 2 commented on their own perspective and how that influenced counseling. This participant reported the following:

> I think as a White clinician, I have to be super aware of the popula'ion that I'm serving. Here in the city, we serve a predominantly Black population so I have to be very aware of the popula'ion that I'm serving. So, w'ether that's understanding racial trauma, asking those questions, understanding the demographics of St. Louis and the kind of physical segregation that happens here in St. Louis. Where are clients coming from? Are they from the South side are they from the North side of St. Louis? And how that plays an impact not only into their addiction, but

> to their mental health, their family grouping and their social status. So yeah, I have to be aware of those things.

The limiting bias approach to addressing social aspects of addiction was also discussed in the focus group. Within the focus group, participants referenced the need for limiting bias and allowing clients to come in with a fresh start. One participant stated, “I think keeping up to date with our own frameworks and checking in with our own biases as therapists is very important.” Similarly, another participant noted, “I guess just to second what others said.’I think it's important to treat everyone differently and come in with a clean slate.” Another participant also highlighted the importance of having diverse staff to help with bias issues:

> We address the demographical piece sort of in a sense what I just mentioned regarding our location but also demographic in ’hat we don't, we do our best not to discriminate and our best to include, hire staff of all diversities. So, we do that to make sure that minorities feel comfortable here.

The participants were acutely aware of the importance of addressing social aspects of addiction by understanding and limiting personal bias.

Culturally sensitive approach. Several participants (n=5) reported attempting to implement a culturally sensitive approach in their counseling. For example, an interview participant shared, “I think that we try to have a culturally sensitive l’ns when we're working with people and really meet them where they are and let the clients define their culture versus us.” This sentiment was reinforced by other focus group participants. For example, another participant stated:

> I think keeping up to date with our own frameworks and checking in with our own biases as therapists is very important. Especially as a white clinician being very mindful of the demographic that we serve and being aware of racial trauma and how those different things impact our clients.

Participant 4 also said:

> I think more and more'lately, we've been very conscious of being sensitive to race and specifically racial trauma and how that exists and what that looks like even in housing and what that looks like in treatment, and what our expectations are and being culturally and ethically, racially humble.

Participant 1 succinctly stated, "Well just looking at each individual and just go check out this diversity, you 'now what I'm saying? And just go from there." It was clear from both the focus group discussion and six interviews that all participants valued cultural sensitivity and understood the importance of incorporating a culturally sensitive approach into counseling.

Addressing social aspect of addiction. Many participants (n=5) described methods they used to address the social aspects of addiction during the focus group discussion and interviews. These five out of six participants emphasized the influence of social components on addiction. One participant from the focus group effectively depicted what social aspects looked like in addiction. Focus group participant shared the following:

> A' humans we're kind of social creatures, so definitely addressing the social aspect of addiction is really important for many people. Either their addiction is very isolating or it was a means to be social and so really working on that in

> therapy is som’thing that's important w’ether that's changing their people, places, and things or working with them on getting connected with a healthy community is really important for sobriety.

Participant 2 also stated:

> I think for many people, and I think that this is something a lot of’people don't understand that addiction is, yes, using drugs or alcohol’ but there's also an addiction to the lifestyle for many people. And for many people that means cutting off and no longer talking to friends, famil’ that they've had their whole life.

In addition, Participant 6 mentioned, “we know bad company corrupts good character.” This participant went on to characterize how the program attempts to address this social component: “A lot o’ times, we'll send them to another agency or somewhere out of town. I know the pr’gram doesn't really fund that, but we do focus on that though.” These five participants understood the influence, both positive and negative, that social connections had on addiction. These five participants also reported the methods that addressed this social component.

In summary, the social aspects of addiction theme were referenced by several participants. The social aspects of addiction theme addressed the third research question by showing the methods that participants used to address the social aspects of addiction. Participants suggested that using a culturally sensitive approach and limiting bias were critical to addressing social aspects. Participants also explained how social aspects contributed to addiction.

Research question 4. How do counselors address the factors influencing addiction relapse?

Addiction Relapse

The addiction relapse theme revealed that counselors do address factors influencing addiction relapse and included information about how participants managed individuals who relapsed. The theme of addiction relapse included subthemes related to the participants' perceptions of relapse and the methods they used to help clients who relapsed. The subthemes were (a) perception of clients who relapse and (b) counseling returning clients, which highlighted the importance of considering relapse in program planning. All subthemes and examples of quotes that motivated these subthemes were provided in the following sections.

Perception of clients who relapse. All participants reported their own perceptions of clients who relapsed. All participants described their reactions to clients who relapsed and sought out the program again during interviews and in the focus group discussion. A focus group participant shared,

> I think that the individualize that treatment. I think that we look back on what happened the last time. 'I think we're really focused and say maybe this needs making a change in their team members, let's kind of maybe mix things up a little bit, see what other alternative routes we could have taken with their treatment and really just nonjudgmentally kind of do behavior mapping of what happened, how they got back to that point?

This sentiment was reinforced by other focus group participants, with an emphasis on the importance of the clients returning for treatment. For example, Focus group 4 participant described the following:

> When we see folks r'turning it's definitely a sigh of relief. What I say to folks who are r'turning it's the only way that you get sobe' is if you're alive, so if you end up dying from this di'ease there's not a way for you to get sober from that. So, you coming back is a huge thing and I think at the site we really, really pump tha' up and we're really positive when clients come back because again there can be a lot of shame. I think, as [participant #4] said, just kind of really figuring out what do we need to change on our end or on the client's end to try to make this time around in treatment successful.

Participant 4 also emphasized the positive aspect of a return client:

> I think actually often we're really excited to see people come back. 'I think it's like, oh, you were doing well really well and you had a slip'. Maybe it's just two steps back and eight steps forward, two steps back.

Participant 1 took this sentiment further saying, "Well you got to understand that relapse is part of the treatment plan and you expect 'that, that's going to happen." It was clear from both focus group discussions and interviews that participants understood that relapse could be a natural part of addiction treatment. The participants were proud their clients returned to treatment following a relapse.

Counseling returned clients. All participants described the steps they took when clients did return for treatment following a relapse. These participants emphasized the importance of considering each client's history when moving forward with treatment

during the interviews and in the focus group discussion. For example, Participant 3 shared, “I try to educate them their previous time here and what goes in it. And try to figure out what was going on it could be violence including weapons and shit.” Participant 4 also stated, “I think we would start with the psycho-education about what we know about the cycle and the disease of addiction and know that unfortunately often relapse is inevitable ’and that it's treatable much like a disease.” In addition, Participant 1 mentioned, “We'll do the process, do the assessments again, and then you start over again. We don't pass judgment. We don't give out judgment. Just come in here, do the assessment and we'll go from there.” Participant 2 shared the following:

> I think when you understand and take time to understand the actual disease of addiction, the rate that people will come back is a majority of people will come bac’, this isn't a quick fix. Even if we address some of the barriers, they still have a disease. And so sometimes it takes several tries, different tries to really address for that long-term sobriety for people. I think that the thing as a counselor and a therapist being most mindful about is when you have former clients coming back, you have to be aware of your own bias.

All participants understood the importance of remaining positive and considering the history of their clients.

In summary, the addiction relapse theme was referenced many times by multiple participants. The theme addressed the fourth research question by demonstrating how participants managed cases of relapse. Participants suggested that relapse was an unfortunate reality amid the addiction recovery process. The participants also explained

how methods like non-judgement and understanding helped clients feel comfortable to seek treatment again.

Research question 5. How do counselors collect feedback from clients concerning the effectiveness of treatment?

Program Effectiveness

The program effectiveness theme revealed that counselors collect feedback from clients and included information about participants' descriptions of the treatment's effectiveness. For example, Participant 4 commented on the successfulness of the program:

> I would call it 70% successful, 30% not unsuccessful but dissatisfying. So that 30% is about, not Christmas time or holidays last year but two years ago, we suddenly had to tell everyone that the funding ran out and everybody had to move out of the housing, that we only had two days left. This was right before the holidays. Busted bubble... I guess the bottom just fell out. The bubble burst and all the funds were gone.

Participant 2 also shared a perspective of the program's effectiveness. This participant noted the importance of measuring success for each individual because the experience was highly personal:

> But for some it's like transportation or a phone, so we got to dig through some of those things to figure out how can we make sure that these services are effe'tive and they're able to benefit the client and not just giving it to them and they have to figure it out on their own.

These two participants believed the programs' effectiveness was highly subjective because each client needed different things to achieve addiction recovery.

In addition to the perspective of program effectiveness described in qualitative interviews, participants also shared additional information about programs used by clients, including prior detox, prior residential, and prior out-patient. This information is presented in Table 4.

Table 4

Client Program Use

Percent of clients	0	1	2	3	4	5 or more
Prior Residential	29.8	26.4	19.5	12.7	4.1	7.6
Prior Out-patient	23.2	33.6	14.8	13.6	2.6	12.2
Prior Detox	24.1	23.8	17.3	11.9	4.1	18.8

Summary

There were five research questions that guided the interviews and resulted in data. The analysis of the interviews and focus group discussion revealed multiple themes related to the five research questions. The first theme, assessments, was composed of two subthemes: assessing need and biopsychosocial assessment. Participants detailed the methods they employed to detect these barriers, including directly asking clients about their needs, conducting a biopsychosocial assessment, and learning more about the clients' history to determine needs.

The second theme, addressing barriers, was composed of participants' descriptions of methods they used to address barriers. These descriptions related to understanding barriers that clients faced and using motivational interviewing to address

them. Participants highlighted the importance of first understanding the barriers their clients faced before attempting to start treatment.

The third theme, suggestions for improvement, was composed of three subthemes: program components, infrastructure, and no changes. Suggestions for improvement related to participants' descriptions of how they believed the recovery programs could be improved. Participants commented on two broad categories that needed improvement: infrastructure and program design. Several participants believed additional funding and staff could improve the program. Other participants felt some aspects of the program design could be improved, such as the inclusion criteria for participating in the program.

The fourth theme, social aspects, was composed of three subthemes: culturally sensitive approach, addressing social aspect of addiction, and limit biases. Social aspects covered ideas conveying the participants' beliefs regarding how social and cultural factors were considered in the program's approach to recovery. Participants described multiple approaches taken to incorporate social and cultural aspects into the program. Participants further noted how critical it was to consider each clients' culture when developing and delivering treatment.

The fifth theme, addiction relapse, was composed of two subthemes: perception of clients who relapsed and counseling returning clients. Addiction relapse included information about participants' experiences when working with returning clients. Participants conveyed their own beliefs and perceptions about these individuals and shared their approaches for counseling them. Participants overwhelmingly reported a positive, non-judgmental response to returning clients. The participants felt excitement and relief when clients returned because clients were still committed to treatment.

The sixth and final theme, program effectiveness, encompassed participant descriptions of their beliefs about the success of the program. Program effectiveness included some brief descriptions regarding the success of programs.

In Chapter Four, the researcher provided an overview of the study results. The overview consisted of a thematic analysis of the data from the interviews, focus group discussion, and field observations. Further, coded and analyzed data was presented in the following chapter. In Chapter Five, the researcher offered reflections on the research findings, other insights, and recommendations for future research.

Chapter Five: Discussion, Reflections, and Recommendations

Overview

The research explored the current State Targeted Response (STR) Program in a Midwest recovery program that addressed increase in opioid abuse and barriers to recovery. The current study employed a qualitative case study design to collect detailed information from study participants that identified themes. Study findings allowed the researcher to contribute to the body of existing knowledge about the effectiveness or productiveness of State Targeted Response (STR) programs.

Discussion of the Results

The research study explored the research findings from the qualitative interviews that were conducted with all 6 counselors and 4 of 6 participants that participated in the guided focus group discussion. There were five research questions that were addressed from the data. The analysis of these interviews and focus group discussion questions revealed multiple themes that were related to each of the research questions. Figure 1 displayed a word cloud that enabled the researcher to view which words were most frequently stated during data collection. The size of the word increases with the frequency with which it was used in interviews.

Research Question 1. *How do substance abuse counselors detect and address potential barriers to addiction recovery?*

The researcher discovered two themes based on this research: assessments and addressing barriers. The first theme, assessments, was composed of two subthemes: assessing needs and biopsychosocial assessment. Participants described specific multiple methods that counselors used for detection of barriers to addiction recovery including assessing need and assessing biopsychosocial factors, such as housing, work, and health.

Previous research presented the Screening Brief Intervention and Referral Treatment (SBIRT) approach as the more commonly used in addiction programs. In this approach, medical staff screen and assist individuals who are not in a recovery program because of refusal to admit having a substance abuse problem but find it increasingly difficult to deal with life issues, such as family, work, and financial issues (DHHS, 2000). The current study showed additional measures that counselors took to evaluate incoming clients. These participants emphasized the importance of assessing needs directly from the client. The main types of assessments these participants used were assessing need and biopsychosocial assessment. The counselors determined that clients had a variety of needs (e.g., housing, goal setting, work). The participants shared the importance of individually assessing the need for clients to reduce some barriers to recovery. Two participants also shared the need to conduct a biopsychosocial assessment to better understand client needs and perceived them as critical for directing client care.

The second theme, addressing barriers, was composed of descriptions of methods participants used to address client barriers that interfere with recovery. Participants described attempting to understand their client's barriers and eliminate or target those barriers once they were understood. Other participants employed motivational interviewing to address barriers. Some barriers that participants identified included transportation, access to services, and housing; these barriers have previously been described in the literature (Scott et al., 2020; McGuire et al., 2020). Access to treatment was one of the barriers that individuals with opioid use disorder encounter (Scott et al., 2020). Hence, enhancing access to treatment is one of the main goals of state targeted responses to address the opioid crisis (McGuire et al., 2020; Scott et al., 2020). The

strategies that have been used to improve access to treatment included community outreach, decision aids, and emergency department-based peer support (McGuire et al., 2020; Mooney et al., 2020; Scott et al., 2020).

Another barrier observed in the existing literature was relapse. For many people exiting from the criminal justice system, relapse created barriers to reentry into the community and reconnection to family and other support systems. Healthcare and other social programs that assisted with the reentry to the real world after incarceration could increase the likelihood of relapse (Dobmeier et al., 2020; Mitchell & Butz, 2019; National Institute on Drug Abuse, 2018). These barriers were identified in the current study during interviews with participants and categorized under the addressing barriers theme. In addition, barriers that were raised by participants that had not been found in the literature, such as transportation and housing were important to consider when developing these recovery programs.

Research Question 2. *Do substance abuse counselors see any need for improvement within the STR to reduce relapses?*

Three subthemes emerged: program components, infrastructure, and no changes. Several participants commented on various aspects of infrastructure that could be improved, such as additional funding, expansion of the program, and staff training. A lack of funding was previously identified as a barrier to the success of the programs (Borda et al., 2021; Germack, 2020; Levin & Cates-Wessel, 2018; Reif et al., 2021). Another barrier that limited the effectiveness of state targeted responses to the opioid crisis was the lack of funding for treatment. The Federal Opioid State Targeted Response (Opioid STR) grant was responsible for providing for the different programs across states

(Reif et al., 2020). Financial resources were important to implement these state-directed programs and policies (High et al., 2020). The current study supported the existing understanding of funding as a major barrier, pointing to the increased need for funding to support addiction recovery.

Five interview participants remarked the program design could be reevaluated. The main aspect of the program that could be improved was the inclusion criteria for clients. Several participants felt that the program was too exclusive, meaning many clients were turned away because they did not meet criteria. The suggestion of expanding inclusion criteria had not been previously described in the literature and is important to reconsider in the modeling of recovery programs.

Research Question 3. *How do counselors address the social aspects of addiction adequately, was addressed by one theme*?

Previous research demonstrated the interconnection between addiction and social influences (Herold & Sogaard, 2018). Social influences were another major factor in drug addiction, especially among teens and young adults. In high school, teens tended to follow the crowd to fit in and that included drug and alcohol use. Friends often had the most influence over another's behavior and could be a major resource for addictive drugs. Therefore, as a result of social influence, there were some difficulties experienced attempting to break the bonds of that friendship that provided a sense of connection and comfort (Herold & Sogaard, 2018). While the decision to use drugs was usually a voluntary decision, the decision to continue drug use implied the lack of ability to exert self-control, which was the earmark of addiction.

There were several theories that attempted to explain the paradox between individuals who used drugs and those that did not even when faced with the same circumstances that prompted drug addiction, such as social influences and the need to fit in even if the user was well aware of the risk of addiction (Dingle et al., 2015). In the current study, participants used three primary methods to address social aspects: limit bias, culturally sensitive approach, and addressing social aspects of addiction. Several participants reported attempting to implement a culturally sensitive approach in counseling. In addition, participants suggested training of staff to reduce bias and increase cultural competency was also important. These techniques have not been previously described in the literature and were important to weave into existing practices and training for recovery counselors. While previous researchers argued the importance of reducing stigma to seeking treatment, particularly focusing on individual factors like culture that could influence treatment seeking, there was no specific research that addressed culturally sensitive methods for drug treatment (Knopf, 2018; Truong et al., 2019).

Research Question 4. *Do counselors address the factors influencing addiction relapse?*

Two subthemes emerged from the addiction relapse theme: perception of clients who relapse and counseling returning clients. Several participants described positive perceptions of clients who relapsed and sought out the program again. These participants emphasized the importance of returning to treatment and valued the clients who made the decision to return to treatment. Participants also shared the methods they used to counsel returning clients. Previous research revealed strategies that helped address relapse

(Giordano et al., 2014; Hendershot et al., 2011). Limited research identified effective strategies to reduce relapse percentages, but the most effective strategies were usually the ones recovery programs seldom used (Giordano et al., 2014; Hendershot et al, 2011). The strategies included the use of interactive teaching methods designed to increase the participant's emotional control capabilities and communication skills and personalized relapse prevention strategies (Giordano et al., 2014; Hendershot et al, 2011; Ruisoto & Contador, 2019; Witkiewitz & Roozen, 2019).

Despite the availability of scientifically derived educational tools, traditional mental (counseling, psychotropic medications), and physical tools (housing, employment, transportation) provided to the patient, there was still a high risk of relapse among opioid addicts (Caputo, 2019; Davis et al., 2019; Kenney et al., 2019). In the current study, participants considered the returning client's history to improve care. The participants emphasized the importance of considering each client's history when moving forward with treatment. A client's history was critical to reframing treatment following a relapse (Girardeau et al., 2019; Ruisoto & Contador, 2019; Sliedrecht et al., 2019). Clients who experienced some form of treatment previously should have received more tailored care to avoid a future relapse.

Research Question 5. *Do counselors collect feedback from clients concerning the effectiveness of treatment?*

In the program effectiveness theme, participants provided brief descriptions about the effectiveness of the program. Previous research has focused on evaluation from the perspective of success rates in reducing addiction and relapse. In general, residential opioid rehabilitation programs have a higher recovery success rate compared to out-

patient residential opioid rehabilitation programs. This is due to the controlled “safe” environment residential programs offered. However, it is more expensive and designed mainly for those experiencing serious, long termed addictions where the individual may have an uncontrollable need to seek out their drug of choice and take serious risks to obtain the drug (Bose, 2020; Morales et al., 2019). They may require larger and frequent doses of the drug and they usually will gradually lose interest in daily activities, such as maintaining good hygiene practices, healthy food consumption. They will have difficulty maintaining relationships especially with those who do not engage in consuming their drug of choice and they will attempt to hide their drug consumption and will express hostility toward those that attempt to address their drug problem (Aston & Cassidy, 2019; Morales et al., 2019). Overall, these participants believed that most clients were satisfied with the program, but there was room for improvement (suggestions will be described in the next section). The lack of responses that were elicited from the current study necessitated a further investigation that will be described in more detail in the following sections in Chapter Five (i.e., reflection on the study and recommendations for future research).

Reflection on the Study

The research study afforded a better understanding of how the current State Targeted Response (STR) Program in a Midwest recovery program addressed the increase in opioid abuse and barriers to recovery. By studying counselors and addict experiences with State Targeted Response programs, the study provided useful insights that helped improve the content of these programs and as a result improved the recovery treatment for clients suffering from addiction. Participants in the study described the

methods that were used in the programs and efforts they made to address the variety of components that contributed to relapses. The data could be used to inform the design of other programs. For example, the approaches to addressing social components of addiction, such as culturally sensitive techniques and taking steps to minimize bias, should be incorporated in the training of counselors and the delivery of treatment. Furthermore, participants in the current study emphasized the importance of understanding barriers that clients faced during recovery. Several barriers like transportation and housing were shared by participants as interfering with their client's success. Barriers, such as these should be considered by counselors when dealing with clients. Counselors offering tele-therapy and access to transportation could be methods used to address these types of barriers.

Another point raised by participants that had implications for future programs and policy was the need for additional funding. The current study supported the existing understanding of funding as a major barrier, pointing to the increased need for funding to support addiction recovery. Participants suggested several ways to expand the program with additional funding, such as relaxing the inclusion criteria for the program could allow this type of program to reach more individuals who need help. Additional funding could increase the reach of these programs.

The current study brought to light concerns that needed to be considered for further research. For instance, additional study is required to help understand how counselors measure the effectiveness of programs from the client's perspective. Limited existing research identified effective strategies to reduce relapse percentages, but the most effective strategies were usually the ones recovery programs seldom used (Giordano

et al., 2014; Hendershot et al, 2011). The strategies included the use of interactive teaching methods designed to increase the participant's emotional control capabilities and communication skills and personalized relapse prevention strategies (Giordano et al., 2014; Hendershot et al, 2011). Despite the availability of scientifically derived educational tools, traditional mental (counseling and psychotropic medications), and physical tools (housing, employment, transportation) provided to the patient, there was still a high risk of relapse among opioid addicts (Caputo, 2019; Davis et al., 2019; Kenney et al., 2019; Langley-Turnbaugh & Neikirk, 2019). The current study attempted to further explore the gap in the literature by identifying additional methods that counselors used to assess program effectiveness. However, in the current study, only two participants contributed information to this theme on program effectiveness. At the time of the study, additional research was needed to determine if additional procedures for soliciting feedback from clients existed and to evaluate if the procedures work.

One of the strengths of this study was that it focused on a critical issue of exploring the current State Targeted Response (STR) Program in a Midwest recovery program that addressed increase in opioid abuse and barriers to recovery from the perspective of counselors. Little focus has been placed on the counselor's perspective of how these programs function. Addressing this topic helped to better evaluate these programs and assess the needs of these programs.

The researcher believed a qualitative case study approach allowed for issues to be explored in depth and in detail. The methodology provided the opportunity for participants to share their perceptions and experiences in ways that are not restricted by a preconceived set of responses (Silverman, 2020). The use of multiple data sources was

another strength of this study. The qualitative data was collected in both in-depth interviews and a focus group discussion. The semi-structured interviews enabled the researcher to answer the five research questions. The focus group discussion allowed the researcher to explore several questions with the benefit of participant interaction which facilitated further discussion of topics.

The first limitation of the study related to the generalizability of the research finding. The research findings could be limited by the geographical homogeneity of the participants, given that the study focused only on counselors in the Midwest. The second potential weakness of the study was selection bias related to participation. There is a possibility that this research topic appealed to a certain subset of the population. If there is bias in this sample, it is possible that findings are not generalizable to the entire target population. For example, participants who agreed to participate may have different opinions about the program than participants who did not participate. Given that 75% of the STR program participants were white men, the results of the study may also not be reflective of the perceptions and experiences of a diverse group of individuals from different demographic backgrounds.

Recommendations for Future Research

The research study provided useful insights into the functions of the State Targeted Response Program; consequently, revealed ideas for future research and programming. The findings of the study were based on the experiences of counselor participants who worked in recovery programs, described as advocates who noted a myriad of obstacles and barriers that clients suffered from addiction faced when enrolling or considering a recovery program. Further research could help to shed more light on the

obstacles presented in this study if these researchers focus on the following program designs. The first recommendation was for programs that are in rural and urban areas. In the current study, participants shared that transportation was frequently a problem for clients. Studying programs in both rural and urban settings could help researchers understand some methods that can be used to reduce the transportation barrier. The second recommendation that arose from this qualitative analysis was additional funding and staffing would help with program implementation. Studying how programs with different staff size function would help funding agencies understand the needs and the abilities of programs based on staff. Lastly, while the research study provided minimal information about participants' feelings or attitudes about the program, future research could look into programs that do not incorporate some type of evaluation. Future research should look into programs that do incorporate some type of evaluation. Research focusing on the feelings of clients would help others developing substance abuse programs determine the best procedures for evaluation and help inform policy and funding issues.

Several changes are recommended based on the findings of this study that could influence policy and determine the future directions of recovery programs. First, is a commitment to increase staffing in drug treatment programs. Several participants believed increasing the number of counselors would improve programs. The increase in staffing would enable programs to serve more clients and perform evaluations. Second, is the need to personalize programs. Several participants suggested that programs could be improved with a more individualized approach that addresses specific client needs. Third, would be to reduce barriers to program enrollment. Most participants raised barriers that

hindered client participation. One major barrier was the inclusion criteria for participating in the program. Participants believed this criterion could be expanded to include more people. These barriers are important to consider in future practice to increase the reach of these programs. Fourth, would be an increase in staff training. Participants shared some methods they used to connect with their clients and ensure clients did not feel judged. These methods included reducing personal bias and using culturally appropriate approaches. These approaches should be included in traditional training for counselors working in addiction recovery programs. Furthermore, participants indicated additional training in assessments would also be useful. Assessments are critical for determining the client's needs and which type of treatment will work best for them. Therefore, increasing or strengthening training in this area would benefit counselors and clients

Conclusion

The research study aimed to fill the gap within the existing literature regarding the current state of State Targeted Response Program in the Midwest and how counselors address the increase in opioid abuse and barriers to recovery. The data collected from the research study addressed the gap and advanced knowledge advances existing knowledge regarding practices within recovery programs. The research study also provided practical implications for counselors and funding agencies regarding possible changes and additions to these programs that could help address barriers for clients and reduce the burden of opioid addiction.

The research study findings suggested there were several barriers' clients face when trying to seek treatment for their addiction, including transportation, housing, social components, and cultural bias from counselors. The research study also showed methods

counselors use to address some of the barriers and provide better treatment for clients. Lastly, the study revealed suggestions counselors had for improving programs.

The current study emphasized the importance of treatment programs in addressing addiction. Despite the increased funding for drug recovery programs attempting to address the opioid addiction epidemic, relapse remains common. The current study's findings allowed the researcher to contribute to the body of existing knowledge about the effectiveness of State Targeted Response (STR) Programs. The research study findings provide practical implications that can mitigate some of the barriers to recovery and reduce relapse. The current study builds on the existing literature and provides a path for improving additional programs.

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Appendix A

Table A1

Initial Codebook

Name	Files	References
address social and demographic aspects of addiction	7	18
methods used	4	4
counselling returned clients	7	18
experience with the program	4	6
methods to detect and address barriers to addiction recovery	6	7
most important aspects of program	6	13
participant background	1	8
perception of clients who relapse and return to program	7	13
causes of relapse	2	4
methods to help clients	1	3
program effectiveness	1	2
suggestions for changing program	6	30
withdrawal from the program	1	1

Appendix B

Table B1

Final codebook

Theme	Subtheme	Example Quote
Assessments	Assessing need	"So we start with our intake admission process, and sometimes, often it comes before then, we are alerted through the EPIC program, which is hospital outreach. And often we get a brief synopsis of kind of some of the presenting concerns a client might have. So they usually are... Before they even come into our door, we know they're homeless, they will need MAT. Maybe they have some kind of complex physical health concerns and probably, usually, they will include mental health diagnoses. So that we know sort of second hand via the client, but kind of based on their self-reporting."
	Biopsychosocial assessment	"And then we go off of that as well when they are admitted into our program, into the opioid SUD program, then they receive a comprehensive bio-psychosocial assessment, which would determine... which includes, it's not limited to the DLA 20, which is the daily living activities 20, which is sort of the benchmark score across the nation everybody uses to determine where are areas of need and where they're successful."
Addressing barriers		"And so asking some of those really direct questions of what do you want to address first? Here's all the things we can help you with, what's a priority to you. And then that's where I think the barriers come in of, we have a lot of things that can help people. And some of those barriers, they just might not have access

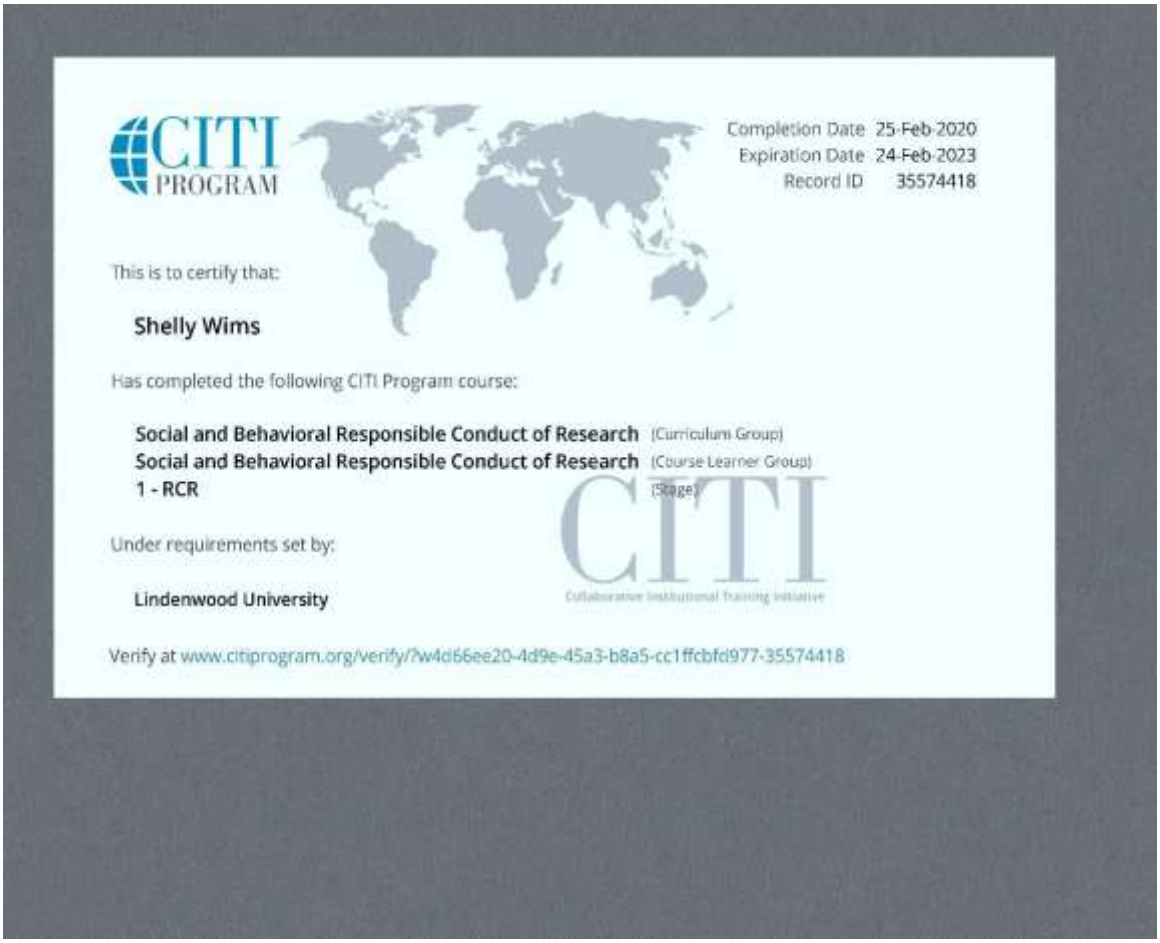
		to some of those services. So we eliminate a lot of times a big barrier for people with just having the services. But for some it's like transportation or a phone, so we got to dig through some of those things to figure out how can we make sure that these services are effective and they're able to benefit the client and not just giving it to them and they have to figure it out on their own."
Suggestions for improvement	Infrastructure	"Yeah, I think the idea that [participant] presented definitely would be one to consider. I also think just expanding that housing in general to have more housing and also just to go along with the basic needs being met. Maybe having vouchers for groceries, for clothes, kind of those other basic needs that sometimes go along with people needing housing. They often need other necessities, as well, so expanding the funding for that."
	Program components	"Okay, I will say that I think the housing criteria, I think initially, and I think still it's written as such to say the [inaudible 00:16:02] STR Opioid SUV program, SOR program, whatever you want to call it, is that you have to be homeless or in need of housing, but I think that it would be better if they used more informal language about what homelessness actually looks like. So, homelessness does not necessarily have to be like living in a tent outside. It could be like staying with your sister on a couch. You know, and that just means you're not on a lease. It's not a long term solution. And so I think that would allow more people to get into the program, to access all the benefits of that program."
	No changes	"And also, I don't want to see anything change. I would just want to make sure that the medication and therapy working together stays as it is. I think it works

		really well when you combine therapy with the MAT program. I would really hate to see it just becoming maybe medication only. I don't think that would really get to the root of the issue. It may help some, but I think therapy in addition to medication is what really helps clients to get better."
Social aspects	Culturally sensitive approach	"Do we address the demographical and ... yeah, definitely, I think that we try to have a culturally sensitive lens when we're working with people and really meet them where they are and let the clients define their culture versus us. Hopefully, as a staff doesn't just assume certain things. I'd like to think that we take into consideration ethnic and cultural differences."
	Limit biases	"Yeah, I do my best to help with that. I had a thought and I just lost it. Well, I guess just to second what others said. I think it's important to treat everyone differently and come in with a clean slate. Like Veronica said, sometimes we tend to look at people and say, oh, well they're maybe from this demographic or from this type of lifestyle so they're going to probably be this way. And while it's important to be at least aware of different people and maybe things that are commonly seen in certain people groups, it's also important to see everyone as just an individual."
	Addressing social aspects of addiction	"As humans we're kind of social creatures, so definitely addressing the social aspect of addiction is really important for many people. Either their addiction is very isolating or it was a means to be social and so really working on that in therapy is something that's important whether that's changing their people, places, and things or working with them on getting connected with a

		healthy community is really important for sobriety."
Addiction relapse	Perception of clients who relapse	"Kind of similar to the way I responded to the first question. I think we are typically pretty relieved. Not to say that we don't have clients that we find a little bit frustrating because it's like repeated return and [inaudible 00:13:15]. I think that we individualize that treatment. I think that we look back on what happened the last time. I think we're really focused and say maybe this needs making a change in their team members, let's kind of maybe mix things up a little bit, see what other alternative routes we could have taken with their treatment and really just nonjudgmentally kind of do behavior mapping of what happened, how they got back to that point?"
	Counselling returned clients	"I think like what's already been said, it's a support and to make sure that the client does not feel judged or any more shame they may already be feeling. I think it's important to meet them where they're at and just kind of go from there and say, okay, well, this is what happened. You relapsed. Let's move forward. What can we do to be different this time, like maybe some more support meetings, some more help you need of some sort. I think like Veronica said there is some relief in knowing that they are still alive and, to be serious, that is something we [inaudible 00:07:55] worry about when a client vanishes. So we're thankful when they're able to come back and try again."
Program effectiveness		"I would call it maybe 70, 30. 70% successful, 30% not unsuccessful but dissatisfying. So that 30% is about, not Christmas time or holidays last year but two years ago, we suddenly had to tell everyone that the funding ran out and everybody had to move out of the housing, that we only had two days left.

This was right before the holidays. Because the bubble... I guess the bottom just fell out. The bubble burst and all the funds were gone."

Appendix C


CITI PROGRAM
Completion Date 25-Feb-2020
Expiration Date 24-Feb-2023
Record ID 35574418
This is to certify that:
Shelly Wims
Has completed the following CITI Program course:
Social and Behavioral Responsible Conduct of Research (Curriculum Group)
Social and Behavioral Responsible Conduct of Research (Course Learner Group)
1 - RCR (Stage)
Under requirements set by:
Lindenwood University
CITI
Collaborative Institutional Training Initiative
Verify at www.citiprogram.org/verify/?w4d66ee20-4d9e-45a3-b8a5-cc1ffcbfd977-35574418

Appendix D

Mendie Schoeller, Chief Compliance and Ethics Office
Preferred Family Healthcare, Inc.
1111 S. Glenstone Ave. Ste. 3-100
Springfield, MO 65804

Dear Ms. Schoeller,

I am writing to request permission to conduct a research study, including the collection of secondary data, at your institution. I am currently enrolled in the doctoral in education (Ed.D) program at Lindenwood University School of Education, Department of Educational Leadership. I am in the process of writing my prospectus for the study entitled: ***Coping with Addiction: A Case Study Exploring the Needs of Struggling Substance Abuse Addicts.***

Specifically, I am requesting permission to recruit six to ten adults who have experienced a relapse after completing the 30-day outpatient rehabilitation process and returned to the program. The recruits will be asked to take to take a short survey using the UPPS-P Impulsive Behavioral Scale questionnaire (see attached Prospectus) and take part in a focus group discussion concerning personal and environmental barriers to sustainable recovery. The purpose of this study is to identify hidden barriers that contribute to the clients' relapse that may not be addressed in the overall program's behavior modification curriculum. Each participant will receive a letter of informed consent (see attached Prospectus), explaining the purpose of the study and their rights as a research recruit, to sign and return to me before taking the survey and participating in focus group activities.

Your approval to conduct this study will be greatly appreciated. I will follow up with a telephone call within the week to answer any questions or concerns you may have after reading the attached Prospectus. If you approve of this study, your signature below, on this document, will serve as consent and permission to conduct this study within your program.

Sincerely,

Shelly Wims
(314) 603-0796 (cell)

Enclosures (1)

cc: Dr. F. Guiseffi

Approved By:

Mendie Schoeller CCEO 1/24/2020

Name & Title ***Date***

Appendix E

Appendix E

LETTER OF INFORMED CONSENT

You are invited to take part in a research study exploring the possible barriers to drug addiction recovery you may have experienced upon the release from the problem. Such barriers may have resulted in a relapse, necessitating a return to the State Target Response program. The researcher will interview men and women currently enrolled in the STR residential program. This form is part of a process referred to as "Informed Consent", which explains the purpose of the research and the research process so that you can decide whether to accept or decline the invitation.

The researcher, ***Shelly Wims***, is a doctoral student at the Linwood University School of Education, Department of Education Leadership.

By signing this form, you agree to the following:

1) You have received enough information about the research project, and you understand the purpose and your role in the process.

2) Your participation is strictly voluntary; you were not coerced in any way to participate.

3) Your participation may involve taking part in a focus group interview *-or-* taking part in a 15-minute survey. I also understand that the researcher will take notes and record during the interview process and subsequent dialogue by audio and or video tape.

4) You have the right to decline to answer any question, verbal or written, and withdraw from the interview process, if you feel uncomfortable with the research method(s) employed. You also have the right to ask the researcher to discard any data collected from you prior to your withdrawal.

5) Your name, address, and telephone number will not be used in any reports generated by this research project, therefore guaranteeing your confidentiality remains intact and properly guarded.

6) You have been assured that this research project has been reviewed and approved by Lindenwood University, Institutional Review Board (IRB), which serves as an independent ethics committee that ensures this research project is conducted in accordance with all federal, institutional, and ethical guidelines that governs the use of humans in research.

7) You have read this document carefully and fully understand its content and all your questions were answered completely and satisfactory.

8) ***You voluntarily agree to participate in this research project.***

Appendix F

Focus Group Structure

A. Introduction and Demographic Information

a. How long have you been a drug addiction counselor?
b. What are the qualifications required become a drug addiction counselor?
c. Why did you choose this career?
d. How long have you worked in this field?
e. How long have you worked for this clinic?
f. How would you describe yourself as a drug addiction counselor?

B. Research Q #1: How do substance abuse counselors detect and address potential barriers to addiction recovery?

g. How would you describe the process of counseling returned clients?
h. How would you describe the most important aspects, if any, of the St Louis STR program?
i. Do you address the demographical and social aspects of addictions? If so, how?
j. How do you perceive clients that relapse and return to the program?
k. How would you describe your experience within the program?

C. Research Q#2: Do substance abuse counselors see any need for improvements within the STR to reduce relapses?

l. Describe what you would like to see expanded, changed, or eliminated from the program, if anything.
    i. Please explain your answer.
m. As a counselor, describe any changes, if any, you would recommend to the St. Louis STR Program?

Appendix G

Interview Questions - Counselors

1.How do substance abuse counselors detect and address potential barriers to addiction recovery?

2.How would you describe the process of counselling returned clients?

3.How would you describe the most important aspects, if any, of the St Louis STR program?

4.Do you address the demographical and social aspects of addictions? If so, how?

5.How do you perceive clients that relapse and return to the program?

6.How would you describe your experience within the program?

7.Describe what you would like to see expanded, changed, or eliminated from the program, if anything. Why?

8.As a counselor, describe any changes, if any, you would recommend to the St. Louis STR Program?

Appendix H

August 14, 2020

Dear Colleague,

My name is Shelly Wims and I am a co-worker in this facility currently enrolled in a doctoral program at Lindenwold University. I am writing to invite you to participate in my research study concerning identifying and addressing drug addiction issues, outside of the traditional focus, that may also play a significant role in the long-term success or failure of outpatient rehabilitation. Examples may include the educational value of the program such as teaching coping mechanisms and how to identify personal triggers; the degree of impulsivity among participants; individually tailored treatment plans; and unaddressed environmental influences.

If such barriers exist, the identification and classification of these barriers could assist the city in developing more expansive, long-term recovery programs and significantly reduce the return rate of participants. You're eligible to be in this study because you are a certified drug addiction counselor in the drug recovery program under the Substance Abuse and Mental Health Service Administration's State Target Response (STR) program. I obtained your contact information from the facility directory and working knowledge of the facility's counselor roster.

If you decide to participate in this study, you will be asked to participate in one-on-one interviews and a focus group discussion. You will receive a $25 gift card for your time, effort, and honesty.

During interviews, I would like to use a voice recorder and generate hand written notes to capture themes and insure accurate interpretation of the information collected. All information gathered will be confidential and all information including observations, interview and focus group notes will be stored in a secured location and shredded before disposal in accordance with Lindenwold University's policy.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email at sw175@lindenwood.edu or contact me at (314) 603-0796.

Thank you very much.

Sincerely,

Shelly Wims

Shelly Wims MA, MNPA, CRADC

Appendix I

Research Questions:

RQ1: How do substance abuse counselors detect and address potential barriers, if any, to addiction recovery?

RQ2: Do substance abuse counselors see any need for improvements within the STR to reduce relapses?

RQ3: How do counselors address the social aspects of addiction ?

RQ4: Do counselors address the factors influencing addiction relapse?

RQ5: Do counselors collect feedback from clients concerning the effectiveness of treatment