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Barriers and facilitators to successful transition from long-term residential substance abuse treatment

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ABSTRACT

Although residential substance abuse treatment has been shown to improve substance use and other outcomes, relapse is common. This qualitative study explores factors that hinder and help individuals during the transition from long-term residential substance abuse treatment to the community. Semi-structured interviews were conducted with 32 individuals from residential substance abuse treatment. Based on the socio-ecological model, barriers and facilitators to transition were identified across five levels: individual, interpersonal, organizational, community, and policy. The major results indicate that primary areas of intervention needed to improve outcomes for these high-risk individuals include access to stable housing and employment, aftercare services and positive support networks; expanded discharge planning services and transitional assistance; and funding to address gaps in service delivery and to meet individuals' basic needs. This study contributes to the literature by identifying transition barriers and facilitators from the perspectives of individuals in residential treatment, and by using the socio-ecological model to understand the complexity of this transition at multiple levels. Findings identify potential targets for enhanced support post-discharge from residential treatment.

1. Introduction

An estimated 21.5 million people have a diagnosable substance use disorder (SUD), representing 9% of the U.S. population, and approximately 40,000 more people engage in misuse that is considered medically harmful (McLellan & Woodworth, 2014; Substance Abuse and Mental Health Services Administration, 2015). Epidemiological and clinical studies suggest that SUDs follow a chronic, relapsing course, with cycles of recovery and relapse, over the course of several years (Dennis & Scott, 2007). Alcohol and drug abuse and related problems contribute substantially to the burden of disease in the U.S., costing an estimated $400 billion annually (Research Society on Alcoholism, 2015; Substance Abuse and Mental Health Services Administration, 2015).

For individuals with chronic SUDs, long-term residential substance abuse treatment provides intensive services combined with safe housing and assistance with daily living. Residential treatment has shown modest improvement in post-discharge substance use outcomes (Gossop, Marsden, Stewart, & Rolfe, 1999; Hubbard et al., 2007). Yet, relapse following discharge is common and may deplete or reverse improvements made during treatment (Carter et al., 2008; Hubbard et al., 2007; Ouimette, Moos, & Finney, 1998). In clinical studies, rates of relapse (e.g., substance abuse, hospitalization, incarceration, readmission to residential treatment) following residential treatment range from 37% to 56% within the first year of discharge (Brunette, Drake, Woods, & Hartnett, 2001; Ouimette et al., 1998; Sannibale et al., 2003). Although engagement in aftercare services has been shown to help maintain the gains achieved during residential treatment (Sannibale et al., 2003), only about half make initial contact with outpatient care and very few complete the recommended duration of aftercare services (Arbour, Hambley, & Ho, 2011; Lash & Blosser, 1999; Sannibale et al., 2003).

Upon discharge, individuals enter a life transition in which there is often difficulty navigating aftercare services and reconnecting with family and friends. Despite the chronic, relapsing nature of SUDs and

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associated problems, traditional substance abuse treatment has operated under an acute care model that assumes successful recovery from substance abuse after a single treatment episode (Dennis & Scott, 2007). Individuals who enter the public SUD treatment system often need longer term care, comprising multiple treatment episodes of varying levels of intensity (Dennis & Scott, 2007; Dennis, Scott, Funk, & Foss, 2005; Scott, Foss, & Dennis, 2005). While residential programs typically provide discharge planning with referrals to aftercare services, few residential programs offer active monitoring and assistance as people transition back into the community (White & Kurtz, 2006).

We know little about the transition barriers and facilitators from long-term residential substance abuse treatment from the perspectives of individuals with SUDs. Using the socio-ecological model as a guiding framework, this study explores the individual, interpersonal, organizational, community, and policy factors that impede and facilitate the transition from residential substance abuse treatment from the perspectives of individuals with SUDs who are anticipating discharge from treatment. The socio-ecological framework posits that an individual's health and behavior both shape and are shaped by factors at multiple levels: individual factors (background factors including race/ethnicity, age, education, employment, housing); interpersonal factors (family and friendships); organizational factors (program-related issues, quality of services); community (community resources, socioeconomic climate); and policy (funding, regulations) (McLeroy, Bibeau, Steckler, & Glanz, 1988). The socio-ecological model is used because it highlights the complexities of transition at multiple levels and considers how multiple layers of influence intersect to shape a person's health and behavior.

In this article, we report transition-related barriers and facilitators, ranging in scale from micro to macro, and provide recommendations that take into account the synergistic nature of these levels. This study is the first phase of a larger initiative to develop a transition assistance model for individuals leaving residential substance abuse treatment. Findings from this study will inform future intervention development that aims to significantly improve short- and long-term outcomes among people with SUDs leaving residential treatment. Knowing what helps and hinders individuals' connections to community resources and aftercare services will provide important information to improve discharge planning efforts and post-discharge strategies to provide effective support during such transitions.

2. Materials and methods

2.1. Setting and participants

We conducted semi-structured interviews with individuals from a long-term residential substance abuse treatment program in New York City. The residential program uses treatment phases to demonstrate resident progress, moving from more restrictive (e.g., limited visitor and outside privileges) to less restrictive (e.g., working and weekend passes) services. The four treatment phases include: Orientation, which does not allow outside privileges in the first 30 days; Level I, which allows day passes; Level II, which allows day and overnight passes; and Level III, which allows advanced privileges including working and weekend passes. The average length of stay at the residential program is approximately 6 months.

A purposive sample of individuals who were enrolled in residential treatment for at least 30 days was invited to participate in the study. To ensure a broad range of experiences and expectations with regard to transition success, we sampled individuals who were at varying stages of their residential treatment. Due to limited resources, only individuals who could speak and understand English were eligible to participate. We recruited a total of 35 individuals, of whom 32 consented and participated in the study. Three individuals were discharged early and were not interviewed. Of the 32 individuals, we interviewed 10 from Level I treatment, 10 from Level II treatment, and 12 from Level III treatment. Recruitment and data collection lasted approximately 4 months, from May 2015 to August 2015. All study procedures were approved by the institutional review board at New York University.

2.2. Recruitment and data collection procedures

Our recruitment strategy included posting flyers in the residential program and referrals from residential staff. Clients who expressed interest in the study met with research staff who explained the purpose and voluntary nature of the study, provided an information sheet, and obtained verbal consent from participants. A waiver of written consent was requested and approved for this study, given that the only record linking the participant and the research would have been the consent document and the principal risk would have been the potential harm resulting from a breach of confidentiality.

We employed semi-structured interviews to allow in-depth insight into individuals' expectations and perceived barriers and facilitators to transition from residential treatment. Three research team members conducted the confidential interviews in private settings at the residential facility. All interviewers had at least a master's degree or higher and prior research experience in qualitative methods. The interviewers received protocol-specific training on interviewing techniques, data management, and ethics and safety. Weekly meetings were held between the principal investigator and research staff to assess and troubleshoot any difficulties that occurred during the interviews.

Interviewers used an interview guide that included questions on prior and current substance abuse treatment experiences, including residential treatment; service needs; discharge plans and expectations; anticipated barriers and facilitators during transition from residential treatment; knowledge of aftercare resources and sources of support; recovery goals and expectations; and sociodemographic information. The core questions related to transition from residential treatment were as follows: 1) What are your plans after discharge from the residential treatment program?; 2) What are you doing to prepare for the transition?; 3) How would you define a successful transition from residential treatment?; 4) What types of supports will be helpful when you transition?; 5) What do you think will be difficult when you transition?; 6) What do you anticipate getting in the way of continuing substance abuse treatment? Have you ever stopped and re-started treatment for any reason? If so, what were the reasons for stopping treatment? Interviewers used follow-up probes to clarify and elicit more detailed information. The interviews lasted between 45 and 90 min in length. Individuals received a $30 gift card for participating in the interview. Interviews were digitally recorded and subsequently transcribed by a professional transcription service. The first author reviewed each transcription for accuracy.

2.3. Data analysis

The research team developed an initial coding scheme *a priori* based on the ecological model described above. Transcriptions of digitally recorded interviews were converted into analyzable text and formally analyzed by three analysts using framework analysis (Pope, Ziebland, & Mays, 2000). The first (JM) and second (YY) authors were the lead analysts. This method allowed for an iterative coding process while also drawing upon the general structure of the socio-ecological model. We first developed broad categories of barriers and facilitators and then modified the categories as analysis continued. Transcripts were independently coded by level of the socio-ecological model by the two lead analysts and then validated by a third analyst. The coded segments in each transcript were discussed line-by-line by analysts and categories were refined using a constant comparative method to ensure consistency and accuracy of the themes according to the socio-ecological model. To increase methodological rigor, we used several strategies: (1) multiple analysts to ensure a broader range and depth of viewpoints and discussions; (2) regular meetings to discuss ambiguities and discrepancies