Research Article | **OMICS International**

Organizational Stress and Trauma: Impediments to the Delivery of User-Involvement Models of Care in Substance Use Disorder Treatment

Kathryn D Arnett[1] and David Baron[2*]

[1]*Steven A Cohen Military Family Clinic at USC, USA*

[2]*Department of Psychiatry and Behavioral Sciences, University of Southern California, USA*

*Corresponding author: David Baron, Professor of Clinical Psychiatry and Behavioral Sciences, Department of Psychiatry and Behavioral Sciences, Keck School of Medicine, University of Southern California, USA, Tel: +1 323 442 4000; E-mail: dave.baron@usc.edu

Abstract

Objective: The objective of the qualitative study reported in this paper was to expand knowledge of substance use disorder (SUD) care best practices, by examining the experiences of residential SUD care participants with user-involvement/oriented care models. These included person-centered, shared decision-making, recovery model and patient/person participation. The goal of the study was to provide a better understanding of the following: each user-involvement model as it relates to residential SUD care from the perspective of residential SUD care participants, the importance of concretizing the concepts for future empirical studies and the development of a nomenclature for the synthesis of the models to inform future empirical studies and assist practitioners with applying the core concepts of the four models in a way that is congruent with the outcomes of empirical studies.

Methods: The author collected data by conducting semi-structured, open-ended, one-on-one interviews with a convenience sample of 12 study subjects between the ages of 24 and 65 years (11 males and 1 female) who self-identified as having successfully completed at least one residential care program for substance use disorder(s). All interviews were recorded and transcribed, and grounded theory methodology was used to analyze the results. The study design was approved by the University of Pennsylvania Institutional Review Board, February 2016.

Results: Data collected from the study subjects represented some degree of experience with all four user-involvement models in residential substance use disorder care. Data also revealed experiences that represented the opposite of the models, and was indicative of care affected by organizational stress and trauma (e.g. burnout, vicarious trauma) and a lack of trauma-informed care.

Conclusion: Subjects perceived the care to be most beneficial in the presence of the user-involvement models; however, quality care was compromised and negated by the presence of organizational stress and trauma and a lack of trauma-informed care. The current study finds organizational stress and trauma and a lack of trauma-informed care not only serves as an impediment to the delivery of user-involvement/oriented care models, but becomes the overarching phenomena that undermines and negates the delivery of user-involvement models of care in residential substance use disorder treatment.

Keywords: Substance use disorder; Trauma; Organizational stress; Anxiety; Mental health

Introduction

Clinicians providing care to persons experiencing substance use disorder (SUD) as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 [1], are aware of the significant negative impact these disorders present to the substance user, their family and society at large. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2013, over 24 million individuals over the age of 12 experienced SUD [2]. In that same report, "In a single-day count, 1.25 million persons in the United States were enrolled in substance use treatment-an increase from 1.18 million persons in 2009." With changes to the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, health insurers were required to provide individuals with SUDs and mental illness the same level of access to insurance as those with medical illnesses [3]. As a result, access to residential SUD care should increase, especially with

the implementation of the Patient Protection and Affordable Care Act [4]. Ideally, increased access will also include high quality, evidence-based care.

A review of the current literature regarding best practices for mental health care, including SUD [5], revealed the importance of applying user-involvement models of care, which include (a) person-centered, (b) shared decision-making, (c) recovery model, and (d) patient/person participation. A recent paper published by the National Institute of Health (NIH) in the Journal of the American Medical Association outlined the characteristics essential to best clinical practices. This included person-centered care models [6]. Care planning with clients provides an opportunity for applying person-centered care. In this model, the client articulates his/her personal goal(s) for treatment. The interventions are collaboratively selected and agreed upon through the process of shared decision-making (SDM), and reflect the needs and preferences of the client. SAMHSA advocates for recovery model in SUD care, where the care provided is holistic, person-driven and culturally driven [7]. In addition, they advocate for

patient/person participation in agency decisions including hosting forums, community meetings, and other opportunities for clients to provide input and share in the vision, development, and quality improvement of the agency. This approach is intended to give clients an active role in their care program and, facilitates ownership and responsibility (congruent with the characteristics of recovery model), offering clients an opportunity to be critical change-agents in the agency's improvement process. Taken together, these user-involvement/oriented models of care provide a framework for SUD care best practices, according to a comprehensive review of the literature [5].

Although the research is limited, user-involvement models of care and processes appear to have a positive impact on SUD care outcomes. A review of the extant literature identified no empirical studies that examined SUD care outcomes based on a synthesis of the four models [5]. Miller and colleagues [8] have been most successful in demonstrating the importance of synthesizing user-involvement models and processes of care in SUD intervention, although they do not define the principles specifically as "user-involvement care models." The meta-analyses conducted by Miller and his colleagues, references the concepts, individually stressing the importance of their comprehensive inclusion as best practices in SUD care, treatment, and services [8]. Nonetheless, current studies that examine the user-involvement models of care in SUD treatment are limited according to a comprehensive review of the literature [5] and represent a great degree of overlap without identifying care outcomes that are specific to each model.

On the surface, simply applying the approaches in a synthesized manner would appear to be an appropriate first step. However, with the mere diagnosis of SUD, clients receiving care for SUD have faced discrimination with respect to the clinical course of the illness. The field is only recently beginning to recognize the importance of removing stigma for persons seeking help [9]. Many prior treatment models have held clients accountable for aspects of their illness. Persons with SUD have had limited control over the course of their care, resulting in a paternalistic approach to care that included shame and blame. The result is varying degrees of client input in their own care and limited empirical studies of outcomes based on a synthesis of user-involvement models of care.

The limited empirical research of residential SUD care outcomes following the implementation of user-involvement/oriented models of care provided the basis of this qualitative study. The key clinical question is, "What is the experience of former residential SUD care participants with user-involvement/oriented care models and processes, which are person-centered care, shared decision-making, recovery model care and patient/person participation."

The objective of this qualitative study was to expand knowledge regarding SUD care best practices. The goal of the study was to provide a better understanding of the following: each user-involvement model as it relates to residential SUD care from the perspective of residential SUD care participants, the importance of concretizing the concepts for future empirical studies, and the development of a nomenclature for the synthesis of the models to inform future empirical studies and assist practitioners with applying the core concepts of the four models in a way that is congruent with the outcomes of empirical studies.

Methods

Subjects

A purposive sample of subjects was recruited to respond to a series of in-depth, open-ended, one-on-one, semi-structured interview questions exploring the experiences of former residential SUD care participants (Appendix A). The following inclusion criteria were used for participants: Adults age 18 years and over who completed at least one residential SUD care/treatment program (short-term, 30 days or fewer of non-acute care, long-term, 30 days or more, hospital residential in a 24 h medical care facility, excluding detoxification), during any period. Responses to questions were based on the most recent episode of care, program completion/clinically driven termination, successful completion, goals attained, diagnosis of at least one SUD at the time of admission. The following exclusion criteria were used: under the age of 18, report of safety concerns, including suicidal or homicidal ideation, intent, rehearsal or plan, individuals appearing to be under the influence of substances, non-English speaking individuals. The protocol and consent were approved by the University of Pennsylvania Institutional Review Board, February 2016.

Qualitative research design

The author chose a qualitative study to explore a topic about which little is known. Given that there are no empirical studies that present outcomes of residential SUD care based on the implementation of a synthesis of the models and processes, it appeared prudent to begin the study by hearing and learning about the experiences of care participants. Following careful review of the qualitative research methodology literature, the author applied the grounded theory method [10]. Charmaz writes that the process of constructing grounded theory begins with a "research question, and proceeds through the identification of participants in the study, data collection, initial coding, focused coding and categorizing, theory building, and writing" [11]. This systematic approach to grounded theory method provided the basis and strategy for conducting this study.

Data collection and analysis

The process of data collection included the following steps: audio recorded interviews lasting 40 to 120 min; complete, verbatim transcription; review and reading of transcribed data; fracturing data beginning with line-by-line, *in vivo* and preliminary codes; writing memos during review of provisional codes, discovering similarities or differences between interviews, relationships between concepts and theory; further fracturing the data and grouping similar codes together; developing provisional categories and themes related to the four models and processes of care that provided the basis for open-ended questions; axial/next-step coding and the development of relationships and dimensions of categories; and the emergence of theory based upon final coding. The author was the sole coder of all clinical data, eliminating any potential for inter-rater variability.

An inductive approach was used to analyze the interview transcripts, identifying patterns in the data by means of thematic codes, in order to generate theory. "Inductive analysis means that the patterns, themes and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis" [12]. The data collection ceased when responses were similar and the data were saturated with information

on the four models examined by the author and in the presence of an emerging theory [13].

Reflexivity

As the research instrument, the author maintained a journal to capture on-going thoughts and feelings of the clients experienced during the study. As each interview concluded, the author recorded the process of recruitment, questions, concepts for further study and relative thoughts and concerns. The author utilized the process of reflexivity to address biases, attitudes and values that affected how the data were gathered, analyzed and interpreted. Contextual data was maintained on each interview to inform the process of reflexivity that included the following: date/time of interview for the purpose of evaluating correlates to quality as indicated; taping/recording concerns; observations made about the subject; non-verbal behavior and/or smells; distractions/sounds heard; demeanor of subject; the author's responses throughout including active listening; the author's overall reaction to the interview; where the data were analyzed; and process of analysis.

Results

Sample description

The total number of subjects for this study was 12 (11 men and 1 woman) (Table 1).

Gender	Age/ Years	Race/ Ethnicity	Diagnoses/ Concerns (Subject's Words)	Total # of Tx/ Dates	Type of Care	Type of Termination or Completion	M and V	Employment Prior to Care	Care funding source	Dual	Relapse after Tx
Male	44	Caucasian	Alcoholism	1 - 12/18/05-1/19/06 32 Days	Short-Term Residential/30 days or less (2 days admin)	"Successful Discharge"	Voluntary	Unemployed	Insurance and Private Pay	Yes, Depression and Anxiety	No, 10 year sober (AA)
Female	55	Caucasian	Alcoholism	9 - Dec 2013-Jan 2014, Apr and Oct 2012, Dec 2011, May 2011, Jun 2010, Jan 2010, Nov 2010/not finished, Mar 2009	Short-Term Residential/30 days or less	Successful completion all except 1	Voluntary all	Unemployed	Insurance and Private Pay	Depression	Not after last Tx
Male	35	Caucasian	Heroin	1 - Nov 06 - Jan 07 (90 days)	Long-term/30 days or more	Successful completion	Voluntary	Unemployed	Insurance and Private Pay	Depression	Yes, Currently OPT
Male	65	Black	Alcohol and Cocaine	3 - Most recent May-Jul 09 (two months)	Long-term/30 days or more	Successful completion	Voluntary	Service-Connected Disabled Veteran	VA/free w/ service-connected disability	Yes, Depression and Anxiety	3 years sober, relapse
Male	53	African American	Schizophrenia, Depression, Alcoholic	10 - Most recent Jan-Feb 2016	Long-term/30 days or more	Successful Completion	Voluntary	Unemployed	Public Assistance	Yes	Yes
Male	54	Black	Crack Cocaine, Depression	5 - Most recent Jan-Jul 2013	Long-term/30 days or more	Successful	Voluntary	Unemployed	State	Yes	Yes
Male	45	African American	Crack Cocaine, Alcohol, Major Depressive Disorder	3 or 4 - Most recent Dec 2011-Jul 2012	Long-term/30 days or more	Successful	Voluntary	Unemployed	State	Yes	Yes
Male	34	Mixed Columbian and Black	Benzo Dependence, Polysubstance PCP Dependence, Psychiatric Issues	3 - Most recent Dec 2015-Jan 2016	Long-term/30 days or more	Successful	Voluntary	Volunteer	Community Behavioral Health	Yes	Yes

Male	46	Black	Heroin, Depression, and Anxiety Disorder	5 - Most recent May-Jun 2015	Short-term/30 days or fewer	Successful	Mandated	Unemployed	Community Behavioral Health	Yes	Yes
Male	50	African American	Crack Cocaine, Alcohol, Schizoaffective, PTSD, Depression, Antisocial Personality Disorder	4 - Most recent May-June 2012	Short-term/30 days or fewer	Successful	Voluntary	Unemployed	Behavioral Health Services Inc.	Yes	Yes

Table 1: Subject demographic sheet (PHI Redacted).

Ten of the subjects reported relapse after participating in their most recent residential care episode. Most of the subjects did not attribute relapse to the quality of care they received. Instead, they attributed relapse to not having followed a continuing care plan. Patterns were identified in the data, which facilitated the emergence of theory. Themes emerging from the data represented all four models and processes, recovery model, person-centered care, shared decision-making, and patient/person participation.

The following are examples in subject's words of how the data represented the models and processes (Chart 1).

MODEL	FOCUSED CODES
Recovery	They [staff] focused on my strengths
	The care was holistic
	They [staff] expect everyone to complete successfully
	We were all a community
	They [staff] had an upbeat attitude
	They talked like I was going to be successful
Person Centered	They [staff] asked me if my needs were met
	Respected where I was
	Talked about stuff not related to drinking
	I asked for dual care and saw a psychologist
	How I learn best or how I best participate
	What I wanted to get out of treatment
Shared Decision Making	I was heavily involved in the care planning
	I wanted to be involved and voice my opinions
	My counselor offered professional suggestions
	I was involved when we made the treatment plan
	I didn't think it would be worth a damn if they didn't ask me
	I had input in what I wanted to do
Patient/Person Participation	At the end there was always a questionnaire to fill out
	We were asked to form a board with a treasurer and secretary
	They had a suggestion box
	We took surveys, "how is staff treating you?"

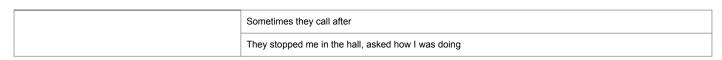|	
	Sometimes they call after
	They stopped me in the hall, asked how I was doing

Chart 1: Codes representing all four models.

Within these data, themes emerged reflecting the presence of the four models (recovery model, person-centered care, shared decision-making and patient/person participation), with a great degree of variation in the delivery of the models. In addition, when all the data were coded, there remained a group of codes, larger than any other group and not represented by any other existing codes or categories. The author further analyzed the codes, which were best represented by a manifestation of organizational stress and trauma (e.g. burnout, vicarious trauma) and the absence or lack of trauma-informed care. Upon comparing the list of codes representing a presence of the models, and the list representing the absence, when it appeared the absence was accounted for by organizational stress and trauma and a lack of trauma informed care, theory emerged.

For example, subjects reported themes consistent with organizational stress and trauma (Chart 2).

Discussion

The most striking aspects of the results of the study are the similarities in experiences articulated by the subjects. Of the four models and processes, the most represented by subjects' experiences was recovery model care. Subjects discussed the value and importance of the relationships they shared with their counselors, whether they respected their counselors and felt respected or whether the counselors focused on their strengths and supported them.

FOCUSED CODES
I was lucky to have a skilled counselor
Some counselors come down hard on people
They [staff] had the opinion addicts deserve what they get
Very punishing point of view
Felt condescending
They thought I was there to pull the wool over their eyes
A lot of addictions counselors are jaded
There were lots of statistics, they said some of us weren't going to make it
They [staff] said I hope she frickin gets it this time
They're [staff] obligated to say positive things
Saw I had repeated failures, asked me how I was going to fix that
They [staff] were judgmental
I wish they would have done more to open me up
You couldn't think for yourself
Everyone did the same itinerary every day
Counselor told me what I needed to work on
They'd say, "you can't tell help how to help you"
Feedback opportunities were limited
Majority of feedback was informal, couldn't be tracked
Don't know if my feedback was incorporated

Chart 2: Organizational stress and trauma and lack of trauma-informed care.

Subjects discussed experiences with person-centered care where they were asked by staff about their needs and preferences and yet, in many cases their experiences suggested that this effort was negated by "one size fits all" care plans. In programs where the resources were available and adequate, subjects reported experiences indicative of a

greater focus on person-centered care, including care for co-existing illnesses.

Shared decision-making, the process of discussion and collaboration between client and provider(s) appeared to overlap with person-centered care in the results of the study. Some subjects reported they were asked about needs and preferences, which was a person-centered approach and they shared in some of the decisions based on their needs and preferences. However, decisions were mostly shared when subjects reported informing their providers that they needed a change or an adaptation to care.

Very few subjects reported experiencing person/patient participation. All subjects recalled signing a consent form for care upon program entry. Only one subject reported being part of forums or panels for program improvement.

When we consider the possibility that there are many people who work in the field of mental health who have experienced trauma, who may also be in recovery for SUD or other mental illness, or who are now re-traumatized by organizational stressors, it is not surprising to imagine that service delivery is naturally impeded as the systems continue to function in an unhealthy or ineffective state of parallel trauma. Service delivery is especially impeded when we, as practitioners, are unaware of the degree to which the care we provide to patients is saturated by the trauma we also experience; hence, the lack of trauma-informed care.

Conclusion

The theory that emerged from these data is that organizational stress and trauma, and a lack of trauma-informed care (including vicarious trauma, and burnout), impedes the delivery of user-involvement/oriented models of care, which includes recovery model, person-centered care, shared decision-making, and patient/person participation. Furthermore, when the impediments exist, not only is the delivery of the four models negated, but the subjects in this study appeared to be re-traumatized and re-victimized as a direct result of what appeared to be staff's own unresolved traumatization.

Bloom has described the ways that organizational stress presents as a barrier to service delivery, especially for patients who have experienced a high degree of trauma in their lives [14]. She discusses the strategies employed by patients to distract from trauma, such as substance use, avoidance, and controlling behaviors. She goes on to add that in work places where there are high levels of organizational stress and trauma, it is likely that staff may develop unhealthy coping strategies in an attempt to manage the high levels of emotional stress inherent in this work. Subjects in the current study expressed concerns about organizational stress and reported a variety of ways that staff disengaged from patients and co-workers.

When we consider the possibility that there are many people who work in the field of mental health who have experienced trauma, who may also be in recovery for SUD or other mental illness, or who are now re-traumatized by organizational stressors, it is not surprising to imagine that service delivery is naturally impeded as the systems continue to function in an unhealthy or ineffective state of parallel trauma. We understand this from an organizational perspective; however, Bloom reports that the phenomena are underrepresented in social and mental health service literature [14].

How do we address these concerns?

Current research [14,15] helps us to understand that while there is a parallel process of illness in the form of organizational stress and trauma, there is a parallel process of addressing it while we simultaneously care for our patients. The process begins with awareness of the issues, including a professional and ethical obligation to work through our own trauma, emotional pain, and any manifestation of organizational stress we experience, regardless of the source. Rather than ignoring, or denying the multiple ways in which our own personal trauma and organizational stress we may be experiencing impedes care, we should address it with our patients in a transparent and authentic way.

Implications for further research

Before we can evaluate the degree to which organizational stress and trauma and a lack of trauma-informed care impedes the delivery of user-involvement/oriented care models, we must first empirically evaluate SUD care outcomes based on a synthesis of the four models. The author recommends adopting "user-involvement/oriented care models" as the terminology or nomenclature used to describe the presence of a synthesis of the four models in residential SUD care. In the present study, residential SUD care participants discussed the importance of all four models, where no one model was more important than another. If a synthesis of the four models is important for enhancing residential SUD care outcomes, there should be a common language used to describe it. This common language could be carried forward from study to study, and if outcomes support a synthesis, this nomenclature could be adopted for practice [16].

Further empirical research would also evaluate specific outcomes of residential SUD care and the achievement of patient-identified care goals following care delivered in a framework based on a synthesis of the four models. Based on the current research, outcome studies may not be promising, unless the studies demonstrated that a synthesis of the models was delivered in the absence of organizational stress and trauma.

A mixed-methods study that includes measurable outcome data and a qualitative exploration of both patients' and practitioners' experiences with the four models could provide a broader understanding of the importance of applying the four models to care. At that point, evaluating the presence and impact of organizational stress and trauma from the perspective of both the participant of care and practitioner could be beneficial.

It might also be important to determine which aspects of care provide the patients with the greatest experience of the four models and which, staff members provide the type of care indicative of the models. Put simply, further research should include the evaluation of the presence of a synthesis of the models in residential SUD care, and the variables that impede their delivery, from the perspective of care participants and staff members. Potential variables are organizational stress and trauma, burnout, vicarious trauma, and evidence of a lack of trauma-informed care. Because of the potential for care to be delivered in the context of organizational stress and trauma, it is important in future research to evaluate the presence of organizational stress and trauma in the SUD program, and if determined absent, engage a study of outcomes based on a synthesis of the four models.

Implications for practice

When we engage in the practice of micro and macro aggression towards patients, including the constant reminder of devastating statistics about relapse and death, we are feeding into our client's desperation in a very anxiety provoking way, which is contraindicated according to the best practices literature [5]. How do we instil hope in ourselves and our patients in the wake of organizational stress and trauma? Are we keeping patients in survival mode when they participate in care in a trauma-saturated environment? If so, how do we move them from survival to thriving? Are we, as practitioners, simply surviving in our organizations? How do we cross the threshold from toxic to healthy, applying care that is truly reflective of recovery model? Perhaps the answers lie in the packaging of the models and the honest and transparent, recognition of the impact of organizational stress and trauma on the care package as whole.

Until research emerges to guide practice in trauma-informed residential SUD care, it is important to take the initiative as practitioners to recognize our own impediments to quality care delivery. We can do this through training on organizational stress and trauma, trauma-informed care, vicarious trauma, and burnout. We can be advocates for trauma-informed care in our work environments, become subject matter experts of these concepts and provide training within our organizations. We can be honest with ourselves about what informs our work and seek our own help and consultation accordingly.

As we learn about the efficacy and importance of care delivered based on a synthesis of user-involved/oriented care models, we can educate ourselves on impediments to that service delivery and those processes that enhance implementation of the models. Perhaps we seek out new research that helps us to counter our experiences with organizational stress and trauma, and a lack of trauma-informed care.

Study limitations

In coding and analyzing this pilot data, a point of saturation occurred with a small sample size. It may be of benefit to explore this topic using a mixed-methods approach with a greater number of subjects, including an equal number of both men and women. The current study might have demonstrated more rigors with the implementation of qualitative study software.

References

1. American Psychiatric Association (2013) Substance related and addictive disorders.
2. Substance Abuse and Mental Health Services Administration (2014) Behavioral health barometer.
3. Substance Abuse and Mental Health Services Administration (2015) Implementation of the mental health parity and addiction equality act (MHPAEA).
4. Public law 111-148 (2010) Patient protection and affordable care act.
5. Arnett KD (2016) User-involvement/oriented care models and substance use disorder care: Review of the literature. J Addict Res Ther 7: 1-8.
6. Bradley KA, Kivlahan DR (2014) Bringing patient-centered care to patients with alcohol use disorders. J Am Med Assoc 311: 1861-1862.
7. Substance abuse and mental health services administration (2012) SAMHSA's working definition of recovery.
8. Duncan BL, Miller SD, Wampold BE, Hubble MA (2010) The heart and soul of change, Washington DC: American psychological association.
9. National Academies of Sciences, Engineering and Medicine (2016) Ending discrimination against people with mental and substance use disorders: The evidence for stigma change. Washington DC: The national academies press.
10. Glaser BG, Strauss AL (1967) The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine.
11. Charmaz K (2014) Constructing grounded theory. Los Angeles, CA: Sage
12. Patton MQ (1980) Qualitative evaluation methods. Beverly Hills, CA: Sage.
13. Padgett DK (1998) Qualitative methods in social work research: Challenges and rewards. Thousand Oaks, CA: Sage.
14. Bloom SL (2010) Organizational stress as a barrier to trauma-informed service delivery. Becker M and Levin B: A public health perspective of women's mental health, New York: Springer.
15. Tosone C (2006) Therapeutic intimacy: A post-9/11 perspective. Smith college studies in social work 76: 89.
16. Arnett KD (2016) User-involvement/oriented care models and substance use disorder care. (Unpublished doctoral dissertation). University of Pennsylvania, School of Social Policy and Practice, Philadelphia, Pennsylvania.