Published in final edited form as:

J Subst Use. 2019 ; 24(6): 587–599. doi:10.1080/14659891.2019.1620891.

What motivates people with substance use disorders to pursue treatment? A patient-centered approach to understanding patient experiences and patient-provider interactions

Laura E. Gressler [PhD Student],

University of Maryland, School of Pharmacy, Department of Pharmaceutical Health Services Research, Baltimore, MD 21201

Nabil M. Natafqi, PhD, MPH, CPH [Post-Doctoral Fellow],

University of Maryland, School of Pharmacy, Department of Pharmaceutical Health Services Research, Baltimore, MD 21201

Bruce R. DeForge, PhD [Associate Professor],

University of Maryland School of Social Work, Baltimore, MD 21201

Barbarajean Shaneman-Robinson, RN [PATIENTS Community Outreach Coordinator],

University of Maryland, School of Pharmacy, Department of Pharmaceutical Health Services Research, Baltimore, MD 21201

Christopher Welsh, MD [Associate Professor],

Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD 21201

Fadia T. Shaya, PhD, MPH [Professor and Vice-Chair for Academic Affairs]

University of Maryland, School of Pharmacy Department of Pharmaceutical Health Services Research, Baltimore, MD 21201

Abstract

Objectives: To identify and define potential positive and negative factors in patient experiences and patient-provider interactions that are associated with the pursuit and maintenance of treatment by those suffering from substance use disorders (SUD).

Methods: Two focus groups with patients in treatment for SUD were performed. The focus groups focused on questions aimed at mapping factors associated with initiating and maintaining treatment along the transtheoretical model of change. Four in-depth interviews with healthcare

Corresponding Author: Fadia T. Shaya, PhD, MPH, Professor and Vice-Chair for Academic Affairs, University of Maryland, School of Pharmacy, Department of Pharmaceutical Health Services Research, 220 Arch Street, 12th Floor, Room 01-204, Baltimore, MD 21201, fshaya@rx.umaryland.edu.

Declaration of Interest

Declaration of Interest: none

Ms. Gressler, Dr. Natafqi, Dr. DeForge, Ms. Robinson-Shaneman, Dr. Welsh, and Dr. Shaya declare that they have no conflicts of interest. This study involved human participants. Informed consent was obtained from all individual participants included in the study. This study was approved by the University of Maryland Institutional Review Board (IRB).

Data Availability

The data that support the findings of this study are not available. The data are not publicly due to IRB restrictions. Data may contain information that could compromise the privacy of the research participants.

providers involved in the treatment of patients with SUD were also conducted to understand providers' perspective on similar factors.

Results: Fourteen patients were included in the focus groups. Patients identified their life prior to treatment as chaotic and further identified internal and external factors that influenced seeking treatment. The four healthcare providers identified primarily social issues such as lack of housing as an external barrier. Both patients and providers cited the importance of a trusting and empathetic relationship between the patient and providers, as well as the patient's willingness to change as primary motivating factors for the initiation and maintenance of treatment.

Conclusions: From a patient and provider perspective, facilitators and barriers for initiating and maintaining may vary by person and are multifactorial.

Keywords

Motivational factors; initiating treatment; maintaining treatment; substance use disorder; qualitative

1. Introduction

Approximately 20.1 million people exhibited a substance use disorder (SUD) in 2016. (Substance Abuse and Mental Health Services Administration, 2017) While this alone represents a daunting proportion of the population, it is arguably not representative of all those in need of treatment. An emerging body of evidence in the literature suggests that a large percentage of this population does not recognize their disorder and only a small percentage pursues treatment. Also, of those patients that seek treatment, 40% to 60% experience a relapse. (National Institute on Drug Abuse, 2012) It is crucial that more effort is exerted to address unmet needs, facilitate progress and prevent relapse in individuals with SUDs. In order to optimize favorable treatment outcomes, the U.S. Surgeon General recommends treatment engagement for individuals who have a SUD for both those who are already undergoing treatment and those who may not yet be ready to enter treatment. (U.S. Department of Health and Human Services, 2016)

Few studies primarily focus on factors associated with the initiation of treatment; most studies focus on the factors associated with maintaining treatment. Previous studies show that perceptions of treatment and social support, defined as the presence or absence of support, the quality of relationships, relationship stability, and substance use status of peers can act as positive and negative prognostic factors associated with the maintenance of treatment. (De Leon & Jainchill, 1986; De Leon & Jainchill, 1986; Tracy, Kelly, & Moos, 2005; Wild, Cunningham, & Ryan, 2006) Dominant cognitive-behavioral models of relapse indicate that the interaction of situational external factors and individual internal factors, such as patient motivation, elevate the risk for substance use after treatment. (Abrams, Niaura, Carey, Monti, & Binkoff, 1986; Ali, Green, Daughters, & Lejuez, 2017; Diclemente, Carbonari, & Velasquez, 2011; Diclemente et al., 2011; Laudet & Stanick, 2010; Laudet & Stanick, 2010; Ryan, Plant, & O'Malley, 1995; Ryan et al., 1995; Upshur, Jenkins, Weinreb, Gelberg, & Orvek, 2018) It is important to meaningfully engage and utilize patient and provider perceptions in order to improve patient recruitment and retention in successful

treatment programs and address their unmet needs. In this study, the insights of patients and providers will be derived through topic solicitation, prioritization, and question framing. (Mullins, Abdulhalim, & Lavalley, 2012)

It is important to understand the factors associated with seeking treatment and achieving recovery. Obtaining the patients' and providers' perspective from focus groups and interviews may lead to a better understanding of the clinical setting in which screening and treatment happen, the etiology of SUDs, and the factors that play into seeking and successful pursuit and maintenance of treatment. This may result in the development of innovations in clinical practice that address the elicited needs and concerns of patients from this community.

The objective of this study is to identify and define positive and negative potential factors in patient experiences and patient-provider interactions that are associated with the pursuit and maintenance of treatment by those suffering from SUDs. This is done by eliciting patients' experiences and perceptions regarding the initiation of substance use treatment and gathering self-reported factors associated with the pursuit of treatment. In addition, this paper aims to understand providers' experiences and perceptions of facilitating patients to seek treatment for SUDs.

2. Material and Methods

2.1 Focus Group and Interview Guides

This study was guided by the Transtheoretical Model of Change (TTM). (Prochaska JO, Redding CA, Evers K, 2002) Developed by Prochaska and DiClemente in the late 1970s, the TTM model is considered one of the classical cognitive behavioral models of change. Prochaska and DiClemente argue that there are six stages of change: pre-contemplation, contemplation, preparation, action, maintenance, and termination. In the first stage (pre-contemplation), people are often still unaware of the negative consequences of their behavior (i.e., substance use) and do not have an intention to change it (i.e., seek treatment). In the second stage (contemplation), people realize the consequences of their behavior and start to consider the balance of pros and cons of changing the behavior. The next stage (preparation) is when people are determined to alter their behavior (e.g., stop using) and start with determining a timeframe for changing or implementing baby steps towards cognitive-behavioral change (e.g., initiating treatment). This stage is often followed by proceeding with the change (action) and acquiring new healthier habits. The maintenance stage aims to sustain the cognitive-behavioral change (i.e., continuing treatment and/or new habits and behaviors) and prevent relapse to earlier stages. The last stage is considered the terminal stage, in which people ideally would not have the desire nor the intention to revert to previous unhealthy behavior and reduce their chance of relapse. However, in treatment of SUDs, relapse and recycling into treatment is very common.

Intervention studies following the TTM theoretical approach demonstrated that this approach is associated with increased participation in the change process. (Prochaska JO, Redding CA, Evers K, 2002) Since relapse during recovery is a very real possibility, it accounts for nonlinear progressions as well. Patients can go through stages multiple times

and regress. The TTM model recognizes that the stages of change do not occur instantaneously and progress takes place over a longer period of time. (Prochaska JO, Redding CA, Evers K, 2002)

Consequently, questions for the focus groups and interviews were guided by the TTM theory and were co-developed with a social worker and a community outreach specialist. Focus group questions focused on the following TTM steps: contemplation, action, and maintenance. Questions regarding the contemplation phase focused on the participant's life and interactions before seeking treatment. The action phase asked about factors associated with the initiation of treatment while the maintenance and relapse phases focused on barriers, facilitators, and influences associated with remaining in treatment and preventing relapse. The focus group and interview questions are shown in Table 1 of the Appendix. The questions focused on perceived barriers for patients to initiate and maintain treatment. In addition, the questions touched upon challenges for providers, their perceived role in a patient's decision to initiate or maintain treatment, and rewarding outcomes.

2.2 Participants

We conducted two patient focus groups in Baltimore City consisting of seven participants each for a total of 14 SUD patients. Focus group participants comprised six males (43%) and eight females (57%), above the age 18 (average age of 49 years), who were receiving treatment for a SUD at the time of the focus group session. Patient participants were primarily African American (93%) and started using illicit substances on average when they were 16 years old. Marijuana was primarily the first drug used (50%), while the current drug of choice was primarily heroin (57%). Most participants (85%) had been in treatment before, and the main treatment of choice was buprenorphine (50%), although all participants participated in counseling, group meetings, or both. Patient participant demographics are summarized in Table 1.

In addition, we conducted four in-depth interviews with providers. Providers worked at a medical or treatment facility within Baltimore and were involved in direct care for patients with SUDs. Three providers worked in outpatient addiction clinics while one provider worked in an emergency department. Of the interviewed providers, one was a peer-support leader, two were social workers, and one was a licensed clinical counselor. Combined, the providers had an average of nine years of overall experience and over six years of experience treating patients with substance use disorders.

2.3 Procedure

Focus group participants and providers were recruited through provider referrals and flyers. The focus groups with patients took place in a treatment center and a community outreach center. They were facilitated by a doctoral health services research student trained in qualitative methods (LEG) and co-facilitated by a community engagement specialist (BRS). Each focus group lasted approximately 90 minutes and followed a semi-structured process following the interview guide. Providers were interviewed one-on-one by LEG, in the provider's office and each interview lasted approximately 60 minutes and followed a semi-structured process following the interview guide. Informed consent was obtained from all

individual participants included in the study. This study was approved by the University of Maryland Institutional Review Board (IRB).

2.4 Coding process and Analysis

All focus groups and interviews were digitally recorded and transcribed. The formal coding used a 2-step process following common approaches of qualitative analysis identified in the literature (Curry, Nembhard, & Bradley, 2009; Natafagi et al., 2017; Stewart, Manges, & Ward, 2015). The first coding process was inductive in nature and followed a grounded theory approach was used to identify themes and appropriate codes (Glaser & Strauss, 1967). Two coders with experience in qualitative analysis (LEG and NMN) independently reviewed the transcripts, going through the text line by line and applying codes that reflect the key categories (themes) and their properties (subcategories) as they emerge from the data (Tolley, Ulin, Robinson, & Succop, 2016). The two coders met and discussed patterns, similarities, and differences in identified themes and subcategories. Themes were adapted, added, and dropped until both coders agreed on the final themes. Subsequently, as a second step, all transcripts were revisited to match previously identified unites (quotes) to each theme identified in the first phase. Exemplary quotes that best illustrated an identified theme were chosen for each theme. The frequency of codes in each theme was also recorded based on the second step. Analyses were conducted with the help of NVivo 12.

We evaluated the data against Lincoln and Guba's criteria for assessing the trustworthiness of qualitative research (Lincoln & Guba, 1985). To establish credibility, we have instituted member-checking procedures to "circle back" to patients and provide an opportunity to approve aspects of the interpretations of the data they provided (Doyle, 2007). Brief memos summarizing themes from focus groups and interviews were shared with participants, who elected to receive the study results. However, due to the sensitive nature of the topic discussed, many patients indicated that they did not want to be contacted after the focus group. Those who were sent the memos, did not contact the researchers back with any changes or recommendations. To establish transferability, we shared the methodology and provided quotes and detailed descriptions of the context and participants in disseminated materials. To establish dependability, we referred to a prescribing clinician and a patient-engagement expert to evaluate the process, findings, interpretations and conclusions. To establish confirmability, we applied analyst triangulation by relying on multiple analysts to code data and review findings.

Preliminary study themes were shared with study participants who elected to receive study findings.

3. Results

3.1 Focus Groups: Patients' Perceptions

The following section describes themes that emerged from the two focus groups. These themes are illustrated in Figure 1. Exemplary quotes that illustrate individual themes for focus groups are shown in Table 2.

3.11 Pre-contemplation: Life Prior to Treatment—The primary theme associated with life before entering treatment was chaos. Patients characterized their life prior to initiating treatment as driven by crime, homelessness, and near-death experiences. Participants pointed out that easy access to drugs lead to a life associated with criminal and law-breaking activities. The lack of resources also contributed to homelessness. Near death experiences referred to overdoses and other life-threatening injuries associated with crime. Individuals that discussed near death experiences prior to seeking treatment indicated that these experiences were not a factor associated with seeking treatment. Participants also described themselves before treatment as having no goals, no purpose other than acquiring drugs, and simply existing.

3.1.2 From Contemplation to Action: Factors Associated with Initiating Treatment—External and internal themes that are associated with the initiation of treatment were identified. External factors included the death of loved ones, family, and the legal system. Loved ones included family members and peers who wanted to see the participant recover before passing away, as well as primary caretakers and friends who died from overdoses. Participants' focus on family included loved ones that they had hurt or the loss of custody of their children. The legal system referred to being court-ordered or sentenced to treatment. Internal factors included health concerns, near death experiences, being tired, and one's self-worth. Health concerns focused on a fear of being exposed to fentanyl and using drugs not to get high but instead to prevent withdrawal symptoms such as nausea or to simply feel well. Near death experiences in this theme referred solely to an experience that contributed to the initiation of treatment. Being tired and considering one's self-worth was referenced the most. Participants who discussed being tired centered on "having enough" of their current situation and wanting their life trajectory to change. They also discussed evaluating their self-worth and knowing that they could do better for themselves. The primary barrier to seeking treatment was fear associated with treatment. These fears included being stigmatized, fear of withdrawal symptoms, and misinformation about treatment.

Participants who entered treatment of their own initiative, mentioned the importance of family, peers, and self as major influences to begin treatment; however, they indicated that providers' efforts to engage them into treatment providers were neither persuasive or influential on their decision. Self-motivation to seek treatment was most frequently referenced followed by the emphasis that providers have little (if any) role in influencing treatment initiation.

3.1.3 Maintenance: Barriers and Facilitators—Regarding maintenance of treatment, the following themes emerged: possession of coping skills, belief in a higher power, structure, surroundings, trust, and wanting change. The possession of coping skills was described as an important aide in the recovery maintenance process, while the lack of these skills made recovery more difficult. A belief in a higher power (e.g., God) and having structure and responsibilities were characterized as being beneficial to treatment maintenance. Surroundings, including family, friends, and workplaces were described as both being beneficial and detrimental to recovery, depending on the situation. For instance,

some family members can provide encouragement and support to quit, while the presence of other family members who use illicit substance in the household may make the recovery process harder. Trust in peers and providers was the most frequently mentioned theme. Participants emphasized that the ability to trust and to feel validation and empathy from the provider contributed to successfully maintaining treatment. The ongoing motivation and the desire to want to change also contributed to continuously participating treatment.

3.1.4 Thoughts on Treatment—Throughout the focus groups, patients shared their overall thoughts on the important characteristics of treatment. Participants emphasized the importance of individualized treatment, the teaching of coping skills, and the relationship with the provider. Another important emphasis by patients was that providers should view their client as human beings and not as a subject in their medical textbook.

3.2. Interviews: Providers' Perception

The following paragraphs describe themes that emerged from the four interviews (Figure 2). Exemplary quotes that illustrate individual themes are shown in Table 3.

3.2.1 Barriers and Facilitators for Patients

Initiation: According to providers, the main barriers that prevented people struggling with SUD from initiating treatment were misinformation about treatment and the stigma associated with treatment.

Maintenance: The main themes providers described for the maintenance of treatment were coping skills, belief in a higher power, meeting goals, surroundings, and a trusting relationship with a provider. The possession of coping skills is beneficial whereas the lack thereof was considered a barrier to successfully participation in treatment and maintenance of recovery. Surroundings, such as living situations and place of employment, were also referred to as a facilitator and barrier depending on whether the environment was positive or negative in help individuals maintain their recovery focus. Belief in a higher power, meeting goals such as acquiring a job or a general education diploma (GED) and having a trusting relationship with their provider were characterized as positive factors in assisting in recovery and maintenance.

Initiating and Maintaining Treatment: Emerging themes that providers discussed as common for both initiation and maintenance of treatment were: low number of available residential beds, long wait times for inpatient or outpatient treatment, family and friends, insurance, clinics that only provide medication without counseling, peer recovery leaders, facing reality, stable housing, transportation, and child care. The low number of available beds in inpatient facilities and the long wait times to see a psychiatrist in outpatient centers were characterized as barriers for initiating and maintaining treatment. Some individuals receiving outpatient care may necessitate a higher degree of care and may be unable to do so due to the unavailability of an inpatient bed. Family and friends were characterized as being either facilitators or barriers to initiating and maintaining treatment, depending on resources available or lack thereof, and personal drug use. Insurance was cited as being potentially a facilitator or barrier, depending on the type of insurance provided. Insurance can make it

easier to receive treatment, however, some insurances plans have high co-pays which introduce further barriers. Medication only treatment centers were described as a facilitator because they are easily accessible to patients who are going through withdrawal. However, medication only treatment was also cited as a barrier because it may deter patients from seeking counseling which is recommended as part of an effective treatment plan. Peer-recovery leaders were characterized as facilitators. Facing the reality of their situation can be a facilitator and barrier. It may help some patients realize that treatment is needed, whereas it may deter patients from seeking treatment due to fear. The lack of stable housing, access to transportation, and childcare were all listed as barriers. Conversely, the presence of these resources was characterized as a facilitator.

3.2.2 Provider's Role

Initiating Treatment: The providers who work in substance abuse treatment programs did not feel that they had a direct role in helping patients initiate treatment. Motivational interviewing, also used for the maintenance of treatment, was the main tool used to assess whether patients wanted or were ready for treatment. The providers acknowledged that the patients must want treatment for themselves and that it cannot be forced.

Maintaining Treatment: Themes associated with the provider's role in helping patients with recovery were case management, helping patients reach goals in and outside of treatment, placing an emphasis on harm reduction, and helping patients understand the benefits of treatment. Case management refers to helping patients navigate aspects of their lives outside of counseling such as finding stable housing or employment and treatment coordination across systems. Case management also allows the provider to help the patient reach goals outside treatment. The provider's emphasis on harm reduction highlights the patient's progress in reducing use and dependence on substances. When a patient is losing motivation, helping the patient understand the long-term benefits of therapy may help motivate the patient again.

Initiating and Maintaining Treatment: The providers emphasized the need to show empathy and validate the patient's feelings. Individualizing treatment schedules to the patient's needs, using motivational interviewing to help the patient understand their own needs, and following up with patients beyond scheduled appointments to demonstrate concern for their overall wellbeing were all important roles that providers found necessary to help patients initiate and maintain treatment.

3.2.3 Perceived Challenges—Perceived challenges were medication diversion, lack of resources, patients with other medical issues, and limited control over policies. Diversion is important to detect and report; however, accusing a patient of diversion may affect the trust between the provider and the patient. Lack of resources include recreational or educational activities for patients, case managers, and access to primary care providers for patient's other medical needs. Patients with more severe mental or physical medical issues may be more difficult to treat and may experience interruptions in their treatment for SUD and other medical conditions. Policies refer to the lack of control over the environment, such as

availability of safe and affordable housing, and lack of regulation over medication-only clinics.

3.2.4 Rewarding Outcomes—The providers reported seeing several outcomes that they considered rewarding in their care of patients with SUD. Those included no or reduced drug use, building a trusting relationship with a patient, and witnessing patients achieve goals such as graduating from programs or finding employment.

3.2.5 Comparison to Patients' Perspective—Patients and providers identified similar factors associated with initiating and maintaining treatment. Both identified family and friends and surroundings as possible barriers and facilitators. Misinformation and stigma were characterized as barriers in both groups. Possession of coping skills and belief in a higher power were facilitators in maintaining treatment among providers and patients. Regarding treatment, the emphasis on individualization of treatment as well as the importance of trust, empathy, and validation between providers and patients, and the idea that the patient must want treatment for themselves were touched upon by both providers and patients.

4. Discussion

Throughout the focus groups, patients placed a continuous emphasis on their sense of self-worth as well as the important role they have in deciding when and how to initiate and maintain treatment. According to patients, providers cannot influence their decision to enter treatment if they were not ready to do so. Instead, patients focused on different factors that influence this readiness, including being sick-and-tired of the lifestyle associated with SUD, and the roles family and peers play in the initiation and maintenance of treatment. Other studies have found similar factors when evaluating the initiation of treatment among patients with SUD. Wilson et al. conducted ten one-on-one interviews with patients and identified the will to “become normal” as a turning point to initiate treatment and maintain treatment. Similar to the results from this study the patients referred to being tired, assessment of self-worth and using substances to prevent from being sick and going through withdrawal. Supportive relationships with family members and religion were also cited as facilitators to initiating and maintaining treatment. Contrary to the current study, participants interviewed by Wilson et al. mentioned methadone as the primary medication using in SUD treatment. In addition, it is important to note that a number of themes identified in this study were similar to Wilson et al. despite different racial and geographic populations. (Wilson, Shaw, & Roberts, 2018)

Providers believe they play an important role in the maintenance of treatment but understand that patients need to make these decisions for themselves. In contrast to patients, providers cite more societal issues as barriers to treatment. There was an important emphasis on housing, medication-only clinics, limited number of beds available for treatment, and lack of familial or peer support. A 2016 study by Timko et al. identified provider-reported patient-level facilitators in interviews with 30 providers. The authors also found that the most frequently identified facilitators to the initiation of treatment were receiving support to enter treatment and self-motivation for treatment. Additional facilitators that were not identified in

this study were previous treatment, proximity, and older age. Provider identified barriers were similar and included stigma, lack of motivation, responsibilities, and co-morbid conditions. Program level facilitators were also cited as aftercare and case management with barriers including limited beds and lack of housing. (Timko, Schultz, Britt, & Cucciare, 2016)

Patients and providers consistently described the importance of trust and empathy between the provider and the patient. Feeling heard, understood, and humanized contributed to successfully maintaining treatment. While patients and providers agree that the willingness to change must come directly from the patient, they differ on the degree to which a provider can play a role. Providers feel that they can impact a patient's decision through motivational interviewing and can help patients maintain treatment through regular follow-up. The use of motivational interviewing by significant others such as family, friends, employers, judges and courts may be a way of helping people with SUDs consider treatment.

This study has several limitations including the small sample size within one geographic area. In addition, study participants were primarily older and African American. The patients are only representative of those who are in treatment meaning they have decided or have been court ordered to start treatment. While participants mentioned several internal and external factors associated with treatment, these factors are multifactorial and may vary by person.

5. Conclusions

This study is the first step in understanding the factors associated with seeking treatment and achieving recovery. The responses provided from the focus groups and provider interviews have provided a greater understanding of the clinical setting, the etiology, and factors that play into substance use disorder treatment from the patient and provider perspective. The results show that facilitators and barriers for initiating and maintaining may vary by person and are multifactorial. Further research comparing these results to people not seeking treatment including those in earlier stages of the TTM model, new users, and recurrent users may be needed. This may inform targeted interventions and future proposals centered on increasing facilitators and decreasing barriers for patients to enter and remain in treatment.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Author Acknowledgement

This project was supported by grant number R24HS022135 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.

Funding

This project was supported by grant number R24HS022135 from the Agency for Healthcare Research and Quality. The funding source had no role in the study design, collection, analysis and interpretation of data, writing of the report or in the decision to submit the article for publication.

References

- Abrams DB, Niaura RS, Carey KB, Monti PM, & Binkoff JA (1986). Understanding relapse and recovery in alcohol abuse. *Annals of Behavioral Medicine*, 8(2–3), 27–32. doi:10.1207/s15324796abm0802-3_5
- Ali B, Green KM, Daughters SB, & Lejuez CW (2017). Distress tolerance interacts with circumstances, motivation, and readiness to predict substance abuse treatment retention. *Addictive Behaviors*, 73, 99–104. doi:S0306-4603(17)30163-6 [pii] [PubMed: 28500908]
- Curry LA, Nembhard IM, & Bradley EH (2009). Qualitative and mixed methods provide unique contributions to outcomes research. *Circulation*, 119(10), 1442–1452. doi:10.1161/CIRCULATIONAHA.107.742775 [doi] [PubMed: 19289649]
- De Leon G, & Jainchill N (1986). Circumstance, motivation, readiness and suitability as correlates of treatment tenure. *Journal of Psychoactive Drugs*, 18(3), 203–208. doi:10.1080/02791072.1986.10472348 [doi] [PubMed: 3772644]
- Diclemente C, Carbonari J, & Velasquez M (1992). Alcoholism treatment mismatching from a process of change perspective. *Alcohol Abuse Treatment*, 115–142. doi:10.1007/978-1-4612-0363-6_5
- Doyle S (2007). Member checking with older women: A framework for negotiating meaning. *Health Care for Women International*, 28(10), 888–908. doi:783775613 [pii] [PubMed: 17987459]
- Glaser BG, & Strauss AL (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, Illinois: Aldine Publishing Retrieved from http://www.sxf.uevora.pt/wp-content/uploads/2013/03/Glaser_1967.pdf
- Laudet AB, & Stanick V (2010). Predictors of motivation for abstinence at the end of outpatient substance abuse treatment. *Journal of Substance Abuse Treatment*, 38(4), 317–327. doi:10.1016/j.jsat.2010.01.007 [doi] [PubMed: 20185267]
- Lincoln YS, & Guba EG (1985). *Naturalistic inquiry*. Beverly Hills, California: Sage Publications.
- Mullins CD, Abdulhalim AM, & Lavalley DC (2012). Continuous patient engagement in comparative effectiveness research. *Jama*, 307(15), 1587–1588. doi:10.1001/jama.2012.442 [doi] [PubMed: 22511684]
- Natafagi N, Zhu X, Baloh J, Vellinga K, Vaughn T, & Ward MM (2017). Critical access hospital use of TeamSTEPPS to implement shift-change handoff communication. *Journal of Nursing Care Quality*, 32(1), 77–86. doi:10.1097/NCQ.0000000000000203 [doi] [PubMed: 27270844]
- National Institute on Drug Abuse. (2012). How to find what you need to know about drug abuse and addiction. Retrieved from https://www.drugabuse.gov/sites/default/files/mediaguide_web_1.pdf
- Prochaska JO, Redding CA, Evers K. (2002). The transtheoretical model and stages of change In Glanz K, Rimer BK, Lewis FM, (Ed.), *Health behavior and health education: Theory, research, and practice* (3rd Edition ed.). San Francisco, CA: Jossey-Bass, Inc. p 99–120.
- Ryan RM, Plant RW, & O'Malley S (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors*, 20(3), 279–297. doi:0306-4603(94)00072-7 [pii] [PubMed: 7653312]
- Stewart GL, Manges KA, & Ward MM (2015). Empowering sustained patient safety: The benefits of combining top-down and bottom-up approaches. *Journal of Nursing Care Quality*, 30(3), 240–246. doi:10.1097/NCQ.0000000000000103 [doi] [PubMed: 25479238]
- Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the united states: Results from the 2016 national survey on drug use and health (No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration Retrieved from <https://www.samhsa.gov/data/>
- Timko C, Schultz NR, Britt J, & Cucciare MA (2016). Transitioning from detoxification to substance use disorder treatment: Facilitators and barriers. *Journal of Substance Abuse Treatment*, 70, 64–72. doi:S0740-5472(16)30103-9 [pii] [PubMed: 27692190]

- Tolley EE, Ulin PR, Robinson ET, & Succop SM (2016). *Qualitative methods in public health: A field guide for applied research*. (2nd ed.). San Francisco, CA: Wiley.
- Tracy SW, Kelly JF, & Moos RH (2005). The influence of partner status, relationship quality and relationship stability on outcomes following intensive substance-use disorder treatment. *Journal of Studies on Alcohol*, 66(4), 497–505. [PubMed: 16240557]
- Upshur CC, Jenkins D, Weinreb L, Gelberg L, & Orvek EA (2018). Homeless women's service use, barriers, and motivation for participating in substance use treatment. *The American Journal of Drug and Alcohol Abuse*, 44(2), 252–262. doi:10.1080/00952990.2017.1357183 [doi] [PubMed: 28806101]
- US. Department of Health and Human Services. (2016). *Facing addiction in america: The surgeon general's report on alcohol, drugs, and health*. (No. HHS Publication No. (SMA) 16–4991). Retrieved from <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>
- Wild TC, Cunningham JA, & Ryan RM (2006). Social pressure, coercion, and client engagement at treatment entry: A self-determination theory perspective. *Addictive Behaviors*, 31(10), 1858–1872. doi:S0306–4603(06)00013-X [pii] [PubMed: 16480834]
- Wilson M, Shaw MR, & Roberts MLA (2018). Opioid initiation to substance use treatment: “They just want to feel normal”. *Nursing Research*, 67(5), 369–378. doi:10.1097/NNR.0000000000000298 [doi] [PubMed: 30052592]

Figure 1 –.
Themes Elicited by in Patient Focus Groups

Figure 2 –.
Themes Elicited by in Provider Interviews

Table 1 –**Demographics of Patients**

	Means/Frequencies	SD/Percentage
PATIENTS		
Age	49.29	11.08
Age Category		
18–40	3	21.42
40–60	8	57.14
60 or greater	3	21.42
Race		
African American	13	92.86
Sex		
Female	8	57.14
Educational Attainment		
No HS Diploma/GED	3	21.43
GED/High School Diploma	8	57.14
Some College or more	4	28.57
Age first Started Using	16.43	3.32
Substance First Used		
Marijuana	7	50.00
Alcohol	3	21.43
Cigarettes	1	7.14
Heroin	2	14.29
Percocet	3	21.43
Cocaine	1	7.14
Current Substance of Choice		
Heroin	8	57.14
Crack/Cocaine	5	35.71
Pain Pills	3	21.43
Ecstasy	1	7.14
None	2	14.29
First Time in Treatment		
Yes	2	14.29
No	12	85.71
If no, how many times?	3	3.82
Current treatment court mandated	3	21.43
Treatment ever been court mandated	5	35.71
Type of pharmacological treatment currently receiving		
Methadone/Vivitrol	2	14.28
Buprenorphine	7	50.00
Type of treatment currently receiving		
Counseling	10	71.43

	Means/Frequencies	SD/Percentage
Group Meetings	13	92.86

*GED = General Education Diploma

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2 –

Emerging themes from focus groups and exemplary quotes

TTM Concept	Theme	Number of Times Referenced	Exemplary Quote
Pre-contemplation	Chaos - Chaotic Life		
	Crime	8	I mean [my life] consisted of crime because I had to live out on the streets to do the crime to get the drugs that I needed for the day. You know it could have been like robbing somebody, possibly leading up to you and killing somebody.
	Homelessness	3	Sleeping in abandomiums, sleeping in cars, sleeping with people I didn't want to just so I could have somewhere to sleep
	Near Death Experiences	4	I [over-dosed] four times, I been [<i>sic</i>] on the operation table two times, one time they brought me back, and I still didn't get it.
	No Purpose	6	I was breathing and I ate sometimes. [I had] no goal to do anything no further than to just get high for that day. Nothing else planned, no other goals, no other anything else.
Contemplation to Action	External Factors Associated with Initiating Treatment		
	Death of Loved One	3	My mother passed away in my addiction and my mama had told me, 'One day if I died tomorrow morning you're not going to have anybody. Please get yourself together.'
	Family		
	Hurting Loved Ones	6	"I wasn't hurting nobody but myself," that's what we say. But I looked at my daughter – I had [over-dosed] and this was about two years ago. I [over-dosed], and when I woke up, I was in the hospital. This was about the third time I [over-dose], and this particular time, when I wake [<i>sic</i>] up in the hospital, I got a great-niece that's looking at me, both of my daughters, and I never thought my son cared, to be honest with you. He was there. So, I got these four people staring at me, and my son asked me a question: "When are you gonna [<i>sic</i>] stop hurting us?" And it brought tears to my eyes, just like now. It took all this time to realize that I wasn't hurting myself, but I was hurting the people that really loved me.
	Loss of Custody	1	So, Christmas Day, I'll never forget, [my daughter] cried to me and said, "Mommy, you know I want to come home," and it tore me up inside, but it took that moment for me to stop everything,
	Legal System	10	So, you know I had to take, I was one of them hard-headed ones, the judge had to offer me a big number, sent me to jail, brought me back, and said, 'you woke now?' So I said, 'Yeah.' He sent me the treatment and I just never looked back. And it took them to give me double-digit numbers.
Contemplation to Action	Fears Associated with Initiating Treatment		
	Embarrassment	1	First thing was, I was kinda embarrassed. I was too young, I shouldn't had to go.
	Fear of Withdrawal	4	The stop – the going through withdrawal, I'm gonna [<i>sic</i>] stop getting high, that I'm gonna [<i>sic</i>] die if I don't get it.
	Misinformation - Not Knowing about Treatment	4	My fear was, "I'm gonna die." [<i>sic</i>] That's what drugs had me thinking. If I come in the program, and I stop getting high, I'm gonna die.
	Internal Factors Associated with Initiating Treatment		
	Health Concern		
	Fear of Fentanyl	7	Come to find out it was Fentanyl in the Percocet. I had never heard of that before. So that scared me.
	Feeling Well/ Normal	5	I stopped getting high a long time ago; it was just a maintenance thing now. Nothing got me high. I just got well, and that was it. That's pretty much it,

TTM Concept	Theme	Number of Times Referenced	Exemplary Quote
			and I did all the ways and means to get it; it didn't matter, whatever I had to do to stay well. That's pretty much it.
	Near Death Experiences	3	1. Death, what I mean by that is I'm supposed to have been dead 2. And it took me eight months to realize that I was the worst kind because I literally should have been dead.
	Tired/Self-Worth	15	1. I'm tired. I'm tired. I'm tired. I don't want to do nothing, really. I don't even want to smoke no weed, which – up and done. I'm just fed up, because I know the next thing gonna be- 2. 27 years of addiction and I was like I was just done, enough was enough. Enough is enough. And, I came in and I haven't looked back since. 3. And for me, it was my self-worth and self-respect [sic]. And then knowing who I was as an individual and having an ego problem. Knowing that I could succeed.
Contemplation to Action	People Wanting you to go to Treatment		
	Family	7	I had a granddaughter – My granddaughter, she asked me, “Granddad, do you love me?” And I told her, “Yeah.” She told me, “Well you gotta [sic] stop smoking cigarettes, and you got to stop getting high,” and at this time, I think she was about eleven years old.
	Not Provider	8	Speaker 1: You can take a horse to the water. Speaker 2: Yeah! But they can't make him drink. Mm-hmm. Speaker 3: We call them oil changes. Speaker 1: It's like those. Speaker 3: It's like oil changes. We go, “Okay, give me that bed.” I'm gonna go in there for three days, get a couple three hots and a cot and something to eat, maybe watch a little TV, feel a little better, shave, take a shower, and then pff! Right back out. It doesn't mean you're ready.
	Peer	5	So, you know when a peer is confronted with another person that has been through the wilderness, I'm going to say, you can kind of relate to them more and believe them more because they have been through the same lifestyle that you have been through. Like the loss of the house, the tricking, the using of the drugs, the robin, the cheating, the stealing, the line, they've been there. But having been given another chance they can relate to the problems that addicts and door.
	Self	12	First of all, you gotta [sic] want it. If you don't want it, it ain't gonna [sic] happen. You can't do nothing to get me in to treatment if I want to get high.
Maintenance	Maintaining Treatment		
	Coping Skills		
	Easier	2	One thing about this program, they teach you therapeutic – how to deal with yourself. That's what I like about it. It teaches you how to deal with what you going through.
	Harder	3	I relapsed, because I had death in the family, and I started back getting high.
	Higher Power - Spirituality	10	That's God. See, I believe in a higher power. I believe that something greater than myself is keeping me clean today.
	Structure and Responsibility	6	The thing that makes recovery easier for me is knowing that I have got lots to follow. I know exactly. I know what I'm trying to accomplish. I know what my goals are. So I already have a platform of things set in stone of things that I know I'm supposed to do and the things that I know that I want to grow into doing.
	Surroundings	4	Just staying away from what I came from. I have to control my surroundings, my environment.
	Trust	5	[...] I started to learn to trust, and then I could open up, and then one thing snowballed to another, and it progressed. I mean, for an addict to trust somebody, my God, that's a feat in itself. I mean, you – trust is one of our biggest problems. Man, self-trust – We don't trust ourselves, how the hell can I trust you?
	Wanting Change	6	I think you got to evolve in the treatment, though, in my opinion. Change, but my change took time to get the mentality to really come in here to try

TTM Concept	Theme	Number of Times Referenced	Exemplary Quote
			and do something about it, and really do the work, not just bullshit through it.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 3 –

Emerging themes from provider interviews and exemplary quotes

Theme	Number of Times Referenced	Exemplary Quote
Barriers and Facilitators		
Initiating and Maintaining Treatment		
Available Beds - Wait Time		
Barrier	8	I think sometimes wait times can be an issue. The moment someone's motivated to enter treatment isn't always when they're able to. So, that delay can mean that they change their mind.
Family and Friends		
Barrier	2	Oftentimes, they recognize that the people I'm spending time with aren't helping me move towards recovery. But it's kinda like who they're familiar with, so it's hard to get them to change those people.
Facilitator	2	Support, whether it's family support, support from friends, support within the community, that's always a big factor.
Insurance		
Barrier	3	There's places that won't take nothing but commercial insurance because we understand that's a business...these places won't take medical assistance, and because of that, the 28-day beds are unavailable for most of the addicts that come through the emergency room
Facilitator	3	If it wasn't for medical assistance, if it wasn't for what they call the Obamacare, there would be thousands of people – thousands of people.
Med-Only Clinics		
Barriers	3	I think one of the barriers that we're encountering now is the availability of med-only docs. So, people can go and get Suboxone from their primary or from doctors that just do meds, and they don't have to do any treatment. So, when they call here, they're just like, "I don't wanna do three days a week at a group if I can just go over here and get it from my regular doctor or go to some clinics where you only have to go 15 minutes every two weeks."
Peer Recovery Leaders		
Facilitator	6	And in recovery, there's a saying that's known worldwide, the therapeutic value of one addict helping another is without parallel. That's why peer recovery is so successful now because it can never be about us without us. We know. And the only way my recovery can be of any value to me is if I'm helping somebody else receive it. So, they always have somebody there.
Reality - Trust	1	
Barrier	7	So, the challenge would be after the honeymoon phase, dealing with the actual reality that they're now facing, and then maybe going back to the burnout, when they've gone to treatment for a while, and the reality isn't changing, and—okay.
Facilitator	4	We also have a saying in recovery, and everybody have their own personal bottom, you have to hit bottom. You have to hit bottom. Everybody has their own personal bottom. Your bottom might be you lost your job, and you never believed you would lose your job. Because everybody has different levels of tolerance for pain, everybody has different perceptions of reality.
Stable Housing		
Barrier	5	So, if they don't have stable housing, it can be really difficult for them to come here regularly and have the funds to show up for their scheduled appointments.
Facilitator	4	Stable housing. I can't tell you the amount of people that we've had in here that will have really unstable housing, or will be living in shelters, or will be doing different things, and do not do well. And then they'll get housing, and then all of a sudden, bam, they do really well, they start making all these changes, they're able to do all these things that we try to get them to do in the

Theme	Number of Times Referenced	Exemplary Quote
		beginning of treatment, but without, it really seems to be that without that stable living situation, it's more difficult.
Transportation - Child Care		
Barrier	4	Transportation is a big issue for people. And that is actually – I'm sorry – that's another thing that we offer. We do tokens for the first month that people are here, and we also have them fill out a form for a temporary disability bus pass, so they can get a monthly bus pass for \$20.00 rather than I think \$70.00 is what it is. But still, transportation tends to be an issue.
Facilitator	2	We offer childcare while people are here right across the hall there. There's the play center. So, while someone is here, or in group, or seeing their counselor, or doing whatever they're doing, they can have their children over there, and it's free of charge. All they have to do is make sure they let them know that their kids are coming whatever days they're coming.
Initiating Treatment		
Misinformation		
Barrier	1	We use a harm-reduction approach, but a lot of times people won't seek treatment because they're nervous that they're gonna have to quit everything all at once. And I've heard people say that that is a barrier.
Maintaining Treatment		
Coping Skills		
Barrier	2	Handling stress is a big one because to get them to kind of work on coping skills prior to something really big happening is a little bit difficult. So, then inevitably, something happens, and they can't handle it,
Higher Power Spirituality		
Facilitator	1	Spirituality helps. Having something. Having – I don't know what it is, if it's church or a mosque. A lot of our patients are of course either Christian centered or Muslim centered.
Meeting Goals - Purpose		
Facilitator	2	So, if they find employment or have some sort of fulfilling hobbies that they do, stuff that kinda takes the place of the substance use, then that makes – I find that that makes people more successful.
Surroundings		
Barrier	2	Or they're running into people they know, and there are always people at meetings that are gonna be getting high or not doing the right thing.
Facilitator	2	That's why it helps to be in those recovery houses, transitional houses, any type of safe structure because not only are you away from what you're used to because you need some time to get people away from that – not only are you away from what you're used to, but you're around people that understand exactly what you're going through because they've gone through it too
Trust in Provider		
Facilitator	2	And then the relationship that they have with their counselor or their group leader. That tends to be one of the biggest things in keeping people in treatment actually is the relationship that they have with their counselor. When they feel like they have that trusting relationship with someone, and they have someone who cares about them for real, and is really able to help them and really wants to help them out, and is able to help them make changes in their lives, and they feel like they can trust, that's a big, big thing for them because for so many of them, they're living this drug lifestyle, and there's no one they can trust in their lives, and certainly no one they can talk to about a lot of the things that go on in their lives or things they've experienced. So, when they feel like they're able to make that connection with someone, that's a really huge thing for them.
Challenges for Providers		
Drug Diversion	5	
Lack of Resources	1	

Theme	Number of Times Referenced	Exemplary Quote
Activities for Patients	3	I think that I would also like to see some more recreational kind of stuff. So, speaking to the other part, which is purpose is meaning, which is what – a lot of people struggle with just boredom and getting high is just something for them to do because they don't know what else to do. I think it would be beneficial to expose our clients to different activities.
Case Management	4	Case management. Case management services, absolutely, to help them get through their day-to-day stuff, to help them find housing when they need housing, to help them find jobs when they need jobs, to help them do GED things when they need that... it's extremely important and it's extremely helpful for people, but it's very time consuming. And so, when we spend our time doing that with them, then we're not able to do therapy in the same way. For me, I believe it's important to have both. They absolutely need to have those things in their lives dealt with as well, but for the most part, most of them do need a good amount of therapy as well.
Connection to other Providers	5	I think connecting people more easily to medical, like primary care.
Patients with Medical Issues		
Mental	2	Mental health can be a barrier where their symptoms are so pronounced that it makes it difficult either in one-on-one or even in a group setting. I have patients that I just see for one-on-one therapy, because they wouldn't be good in group, because of their mental illness, which is good, but then they don't have the kind of the social piece. So, there's that.
Physical	2	Medical issues. A lot of my patients, both because of their drug use and just kind of an unhealthy lifestyle or unhealthy lifestyles in general, they'll have a medical crisis. Either they'll present with one when they first come or they'll develop one while they're here, and they'll have to be hospitalized or they'll have to get, you know, some sort of medical procedure, and then that interrupts treatment. Very often, they have to – they're given opioids for pain management, and that's another issue is pain.
Policies	1	And I think the large-scale drug – and this is getting into some other like – but I do feel that large-scale drug use in a society is really indicative that that society isn't really meeting the needs of its members. So, it's not like an – it's on the individual level that all these people are weak somehow and that they're getting addicted to opioids. I think that there's mass unemployment, there's housing – just name a few issues in Baltimore City that's just – that's like big-picture stuff that I think contributes, too.
Control over Environment	3	I think it's just like you feel sometimes like your hands are really tied in what you can offer. So, I can't go build a community center in your neighborhood. And I can't make so that good-paying jobs are available all throughout the city, in all neighborhoods. I can't help that Baltimore's bus system is incredibly inefficient. There's so many things that it's just – it's hard for me to reassure people when it just is what it is. They're like, "Oh, people are selling drugs in my neighborhood. I'm really feeling like, what's the point? Or like, "I can't do this." I'm just kinda like, "Yeah, that sucks." There's nothing I can really do about that.
Lack of regulation on Med-Only Clinics	1	I think there should be some more regulations on the medication. I don't think it's a good idea for people to just be able to go to their regular doctor and get Suboxone and never have to do any kind of treatment. I feel like that sets them up for failure
Providers' Role	1	
Initiating and Maintaining Treatment		
Empathy - Validation	10	You have to be nonjudgmental. You have to be like, "Yup, it's what it is. That's what it is." It doesn't mean anything really, whatever things they're telling you about. You have to be empathetic. When they're talking to you, you have to be able to kind of let them know that you understand what they're going through and what they're saying, and empathize with them and go, "Yeah, that was hard," or, "Yeah, that really sucks," or, "No, you're right, that's not fair," or, "This really was really bad, but you can get through it," and you need to be able to offer them hope when they look at you. And you can say, yeah, this was this, but these are the things that we can work on.
Individualization of Treatment	6	-more like they have a choice and some control over what goes on, that's always a big thing, so I think doing individualized treatment is real important. There's, I think, structures set up that this is what you do when you do treatment. You do groups, and you do this, and this is what treatment is. I don't think it has to be that way. I don't think everyone does well that way, so I think making more room for individualized treatment is important too.
Motivational Interviewing	10	Usually, sit down and talk to them and try and figure out what's going on. Are you feeling less motivated? Is there something that's come up that's not allowing you to come in so much?

Theme	Number of Times Referenced	Exemplary Quote
Reaching Out - Following Up	5	That's really kind of the best thing we can do with them is just talk to them and try and see what's going on and try to make sure that we're reaching out to them when they're not here, so they know that you're still interested. Very often, they really appreciate the fact that you've called them. They're like, "Oh," because they're just—
Solely Maintaining Treatment		
Case Management	2	I know that when I do a session, I will try and make it a blend of therapy and case management meaning if it's something that I can do immediately like make a doctor's appointment for them, I do that. We'll find them a primary care physician when I do that. Some sessions will be, well, let's just do your resume, you know? Let's do your resume.
Emphasis on Harm Reduction	5	Yeah, that's like harm reduction. I am a very harm reduction-oriented person, so I celebrate the small stuff, and I see progress as progress. I don't measure progress in, are they totally abstinent from all drugs or not?
Helping Reach Goals- Providing Hope	7	I validate that it's gonna take a long time for you to work. I sometimes will take the attention off of their drug use and sort of refocus the conversation on like, "Okay, what can we work on? If you feel like the idea of quitting dope forever and ever is really difficult for you, is there other stuff that we could work on right now? How about we get you in to see your doctor? How about we...? How about you apply for a job? Even if you're still not perfect with the dope, how about you apply for some jobs or do something that will make you feel good about yourself?"
Understanding Benefits and Reality of Treatment	4	Gosh. I think for the most part, there are a lot of people that sometimes they just get burnt out on it – I call it burnt out on it – that they've been coming for months and months and months, and if they don't feel like they're doing a whole lot better or 100 percent better, they're just like, "Eh, I've been through this. I've done this." And we'll have clients that were like they've been in this group forever, what do we need to change because something's not changing. So, we – And sometimes, they're not even reaching their treatment goals. And I think sometimes it just takes a little bit longer than what they think it's gonna take. So, I think there's that. Sometimes you get the lack of motivation from people that in the beginning, they're in kind of the honeymoon phase where everything's great because I'm not getting high anymore, and everything feels great, and they're doing well, and then all of a sudden, all these problems start hitting them that they haven't dealt with. And so, that gets really stressful, and they're like, "Well, life sucks. This is no fun."
Rewarding Outcomes	5	
No or Reduced Drug Use	4	When they've been clean for a little bit, I think especially – and this is more with marijuana clients because with opioids, if you don't use for three days, you're clean, you're good. So, they know. They've had plenty of times where they're coming up clean, not clean, clean, not clean. It can be more sporadic, where with marijuana, for the most part, it's 30 days, and you have to wait that 30 days before it comes out, so watching them as their numbers are coming lower and watching them be excited about it, that's always a really cool thing.
Trusting Relationship	2	Having the relationships that I do with my patients and knowing that I might be the only person that they come and meet with that provides some sense of sanity for them and that is helpful, that's not trying to get anything from them, that will spend as much time listening to them as they want. If I don't have a patient after an hour session, I'll just keep going for a two-hour session, two-and-a-half-hour session. We'll just keep going.
Witnessing Achievement of Goals	5	And watching them meet their goals when they're like, "This is what I wanna do," and they start doing that, and they get really excited about, "Hey, this is what we talked about. I went out and I did it." That's what you work for, you know what I mean?