



Stakeholders in Recovery: Demands, Expectations, and Research Opportunities

A broad array of agencies, institutions, and individuals interact with community-based substance abuse treatment programs, providing resources or services and asserting demands and expectations in return. These relationships shape the environment in which treatment and community-based research take place, and themselves raise issues worthy of research attention. This article enumerates the stakeholders in one well-established program and describes the scope of the program's efforts to accommodate these stakeholders, along with some of the complications and difficulties programs confront in their attempts to satisfy stakeholders, especially when their demands are unrealistic or their interests conflict. The article concludes by identifying research areas that could facilitate these relationships, enhancing their benefits for patients.

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Willamette Family operates three facilities in Eugene, Oregon, serving more than 1,500 individuals with alcohol- and drug-related problems each year. The Men's Treatment Center provides residential (20 beds) and outpatient services. Fifteen minutes away, the Women's Treatment Center provides residential (35 beds) and outpatient services for women, who make up 40 percent of Willamette Family's patients. In yet another neighborhood, the Buckley Detoxification and Sobering Station has 12 beds (including 3 for women) and a cell-like room that holds 22 individuals while they get sober. Receiving patients 24 hours a day, 7 days a week, Buckley is a rescue station for the most drastically addicted individuals and a starting point for recovery.

Willamette Family is subject to legislative and regulatory oversight, of course, and relies upon relationships with health, social service, and civic organizations to maintain its licensure, provide clients with the services they need, and advocate for an environment conducive to carrying out its mission. Stakeholders sort into four main groups according to what they provide: referral sources; ancillary and support services; payers and regulators; and workgroups and professional organizations (see "Some Stakeholders for Willamette Family"). A roster that is by no means exhaustive comprises over 100 different institutions and classes of individuals, each with its own goals, views, and leverage.

Willamette Family and its staff devote abundant energy and resources to accommodating these stakeholders. Like other substance abuse programs, they are striving to meet policymakers' and regulators' specifications for evidence-based practices and making admissions decisions with an eye to the agendas and needs of referral sources. Staff members divide their time between patient care and meeting payers' and regulators' demands for bookkeeping, reports, and certifications. Management and staff work together to build linkages with the local drug court, cultivate relationships with local senators and representatives, foster collaboration with the local police department, and partner with the business community. They serve on community boards; testify before city, county, and State budget hearings; and advocate for improvements in client services. They also speak to civic groups and fraternal orders (e.g., Elks and Rotary); promote the United Way; and sit in monthly meetings with corrections officers, the county health and mental health clinics, and alliances of service providers. The efforts to build, strengthen, and mobilize stakeholder relationships for the good of patients extend far outside the workplace and beyond compensated time.

A complicating fact of life for Willamette Family and other substance abuse programs is that stakeholders make demands that are unrealistic or conflicting. For example, employers and families pin their hopes on permanent cures despite the reality that substance abuse is a chronic illness and patients are prone to relapse. Child welfare services threaten permanency placements before mothers in early recovery are fully prepared to care for their young families. Schools refer children who have struggled for years with learning difficulties, then express perplexity that short-term interventions do not produce enduring change.

Programs rely on education and skillful diplomacy to pursue optimal results in the face of stakeholder ambivalence. Individual stakeholders frequently are self-conflicted. Patients concurrently seek treatment and deny that they need care. Parents crave a better life for their children, but resist changing themselves in ways that will foster that outcome. State and county policymakers impose contradictory conditions on programs, cutting budgets while demanding investment in evidence-based practices and increases in program effectiveness.

Many patients' individual needs are such that the program must mobilize multiple stakeholders

to meet them. Often, stakeholders in one patient's outcomes stand at cross-purposes with each other. Programs must seek a mutually satisfactory response, for example, when courts and departments of corrections, whose primary interest is public safety, mandate lengthy residential treatment in secure settings, while health plans require brief treatment in the least intensive environment. Communities demand more care, while neighbors resist and protest expansion efforts.

Programs confront the issues of stakeholder conflict most commonly, perhaps, when treating clients with co-occurring mental health and substance use disorders. These cases tend to involve the most stakeholders because of the exceptional number of community services these men and women require. Moreover, substance abuse and mental health programs historically have had problems forming good collaborative relationships. Programs also encounter substantial potential for stakeholder conflict when treating adolescent patients. Families routinely disagree with courts; juvenile justice, child protection, and school representatives all have their opinions on the most appropriate care. Disagreements on the nature and duration of treatment are common, and subtle conflicts are the norm rather than the exception. In a context of limited financial resources, programs must balance competing claims for access to services coming from courts and corrections, employers, schools, and families.

QUESTIONS FOR RESEARCHERS

Stakeholder demands, ambivalence, and conflicts all give rise to specific issues that research might clarify, to the benefit of all parties. The suggestions that follow are not exhaustive, but represent those that probably have the most immediate and far-reaching potential for helping programs like Willamette Family.

Nationwide, policymaking agencies are escalating pressure on programs to implement evidence-based practices. Willamette Family and its counterparts are striving to meet this challenge. Willamette Family counselors who work with girls and women know, for example, that they need to address trauma, attend to signs and symptoms of childhood sexual abuse, link with psychiatric and primary care, and promote smoking cessation. They use motivational interviews; involve families; facilitate 12-step and other support group participation; encourage patients

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to use medications and educate them about the risk of contracting HIV and hepatitis C; and address needs related to mental health, criminality, and physical and reproductive health. However, staff members are unsure they are providing state-of-the-art care because little research has specifically looked at the types of patients they treat—largely, people with co-occurring disorders and criminal histories. Research that could provide guidance to counselors on which evidence-based techniques work best with various patient groups would be very welcome.

Among the potentially highly effective evidence-based practices are new pharmacotherapies, including buprenorphine and selective serotonin reuptake inhibitors. However, counselors in many community-based programs have little training in the use of medications and are often skeptical about their value. These programs would greatly benefit from research on how to most effectively introduce medications into treatment environments that have few medical supports and little training in the use of pharmacotherapy.

Programs would also greatly benefit from research to better articulate the mechanisms for fostering and supporting complex behavioral therapies. Identification of highly effective strategies for training counselors, in particular, is a priority need. Currently, Willamette Family counselors rely primarily on supervisors, conversations with colleagues, and conferences and training to stay up-to-date on emerging therapeutic strategies. This is the case even though Willamette Family has exceptional access to research-based information as a result of its participation in NIDA's Clinical Trials Network and in an initiative to develop residential services for adolescent girls. For reasons that research could illuminate, counselors and management tend not to consistently activate information they receive from research-related sources or from national and State list serves. Papers in academic journals tend to go unnoticed.

Another challenge that warrants research input is that of optimizing the programs' interaction with stakeholders over the information infrastructure. Willamette Family's experience in this respect typifies that of many programs: The program expends staff time to participate in the State's client database, but does not itself retain the information electronically and receives little feedback from the State on patient numbers and characteristics. Lacking both

data and staff trained to analyze it, Willamette Family relies on the responses of partner agencies and patient surveys to gauge the quality of its work. While both measures consistently give the program excellent ratings, they provide neither an ideal level of assurance nor opportunities for strategic, precisely targeted improvement initiatives.

Stakeholder competition for access to treatment resources raises additional questions worthy of research. The queue for treatment is often long and patients who spontaneously seek assistance often are the last to gain entry. As client motivation affects appropriate treatment approach, length, and outcomes, admission delays potentially have significant consequences for overall program efficacy. Research to assess the benefits and burdens of current admissions policies could point the way to beneficial adjustments. Such research would enable programs to strike an optimal balance in allocating beds or classes to patients referred by various stakeholders, and to present empirical justification for their admissions policies to courts and corrections agencies, employers, schools, and families.

Finally, the demands and the push-and-pull exerted by different stakeholders influence staff morale. The drug abuse treatment workforce is defined perhaps primarily by caregivers' high level of commitment to their mission, yet it is also characterized by extremely high turnover. Along with low pay, relatively low prestige, and the difficulty of the job, many of the tasks stakeholders impose and the concomitant diversion from patient care—which clinicians regard as their essential function—apparently contribute to the high turnover rate. Research to explore these relationships and generate strategies to minimize turnover could contribute substantially to program stability and enhanced treatment results.

CONCLUSION

Community drug abuse programs cooperate and contend with a remarkable number and variety of stakeholder organizations, institutions, and individuals. They invest substantial resources in building and maintaining effective collaborations with stakeholders and work with many facets of the community to meet treatment needs while complying with regulations, ordinances, and payer requirements.

Researchers can greatly enhance drug abuse treatment in the Nation by addressing a number of issues that arise directly in relation to stakeholder expect-

SOME STAKEHOLDERS FOR WILLAMETTE FAMILY**	Referral Services	Ancillary and Support Services	Payers and Regulators
INDIVIDUALS			
Clergy; family members; friends; pediatricians; psychiatrists; psychologists; roommates; school counselors; social workers; 12-step sponsors	x	x	
COMMUNITY SERVICES			
Crisis and Disability			
Eugene Police	x		
Community response team (homeless services); services for seniors and the disabled; sexual assault support services; victim awareness program; WomenSpace Domestic Violence Services		x	
Culture and Recreation			
Agricultural Extension Service; Camp Avalon for Girls; Centro Latino Americano; Emerald Valley Boys and Girls Club; Eugene Library; Eugene Parks and Recreation; Parents, Friends and Family of Lesbians and Gays; University of Oregon Natives Program; YMCA/YWCA		x	
Education and Employment			
Alternative schools; elementary/middle/high schools; Head Start; Lane County Community College; Sponsors, Inc. (prison release support); Transitions program for women; United Way	x	x	
State Unemployment Office		x	
Health and Mental Health			
Counseling centers; HIV Alliance; Impact (coordinated case management for the seriously mentally ill); local dentists and hospitals; school-based health clinics; tribal and local emergency facilities	x	x	
Primary care; primary care plans in Oregon's health plan; private health plans and health insurance companies	x	x	x
Psychiatric hospitals; substance abuse treatment programs (n=20+)		x	
Parenting and Family			
Birth to Three; Child Advocacy Center; Commission on Children and Families; court-appointed special advocates; EC CARES (early childhood assessment); family and adult shelters; Food for Lane County; foster homes; Lane County Relief Nursery; Mutual Home for Single Moms; open adoption services; Women, Infants, and Children program		x	
Religious and Spiritual			
Catholic Community Services; Lutheran Community Services; local churches; Pearl Buck Center; Salvation Army; St. Vincent de Paul Charities; 12-step organizations	x		
Government Agencies			
Clackamas and Deschutes Counties alcohol & drug agencies; Federal Bureau of Prisons; Department of Veterans Affairs; LaneCare (County mental health carveout); Lane County Alcohol, Drug and Offender program, Department of Youth Services, drug court, jail, probation officers; Oregon correctional institutions; Office of Mental Health & Addiction Services; parole and probation agencies	x		x
Josephine County Juvenile Department; Lane Regional Program for the Deaf and Hard of Hearing; public defender's office; West Eugene Teen Court	x		
Lane County departments of health and mental health; Lane County Housing Authority; Oregon Treatment Network; services for children and families	x	x	x
Lane County Prevention Coalition; Lane County Psychologists' Association		x	
Grand Ronde Confederated Tribes; Siletz Tribe; Oregon Vocational Rehabilitation; U.S. Department of Housing and Urban Development	x	x	
Oregon Office of Medical Assistance Programs (Medicaid)			x

*Willamette personnel also participate in many workgroups and professional organizations, omitted here for lack of space.

tations, demands, and conflicts. In undertaking community-based research, they will enter an environment rife with expectations, demands, complexities, and conflicts. And, they will become stakeholders themselves.

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