

# Substance use disorder patients' expectations on transition from treatment to post-discharge period

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Dagny Adriaenssen Johannessen 

Blue Cross East, Oslo, Norway

OsloMet – Oslo Metropolitan University, Norway

Trond Nordfjærn

Norwegian University of Science and Technology (NTNU), Trondheim, Norway

St. Olavs Hospital, Clinic of Substance Use and Addiction Medicine, Trondheim, Norway

Amy Østertun Geirdal

OsloMet – Oslo Metropolitan University, Norway

## Abstract

**Aim:** There is limited knowledge about how inpatients anticipate factors that facilitate the transition between specialised inpatient treatment for substance use disorder (SUD) and the post-discharge period. This study explores factors that inpatients anticipated would facilitate such a transition period. **Method:** A focus group study, consisting of four group interviews with individuals in inpatient SUD treatment, was conducted to explore their expectations for the transition and post-discharge period ahead of them. The transcribed interview material was analysed using thematic analysis. **Findings:** The analytical process led to three themes: “Belonging”, “Intrapersonal processes” and “Predictability”. Correspondence between inpatients’ expectations and the services they are offered in the transition and post-discharge period may serve as proper support for inpatients ahead of a vulnerable phase, such as the transition and post-discharge period. **Conclusions:** Findings from the current study highlight overarching elements that inpatients envisioned to be facilitating, such as social support, motivation, self-efficacy, self-awareness

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## Corresponding author:

Dagny Adriaenssen Johannessen, OsloMet – Oslo Metropolitan University, Department of Social Work, Child Welfare and Social Policy, Pb 4, St. Olavs plass, 0130 Oslo, Norway.

Email: [dagnjo@oslomet.no](mailto:dagnjo@oslomet.no)



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and predictability in basic elements such as employment, housing and personal finances. Findings from this study and previous ones imply that certain factors appear to facilitate in vulnerable phases, such as service level transitions. These facilitating factors should be taken into consideration and used as steppingstones through the transition and post-discharge period after inpatient SUD treatment.

## Keywords

care transitions, continued care, inpatient treatment, recovery capital, substance use disorder

In the addiction field, there is limited knowledge about factors that inpatients with substance use disorders (SUD) perceive to facilitate the transition between inpatient treatment and the post-discharge period. Findings from a systematic review of expectations in other patient populations suggested that patients' expectations ahead of a treatment intervention correlated with treatment outcome; fulfilled expectations were associated with positive treatment outcome, and positive expectations were associated with a desirable treatment outcome (Waljee, McGlenn, Sears, & Chung, 2014). Previous research has mostly presented knowledge based on individuals' experiences following a transition between inpatient SUD treatment and the post-discharge period. The current study extends this knowledge by providing insights into inpatients' expectations prior to a transition from inpatient SUD treatment to the post-discharge period.

The "transition period" refers to the last phase of the inpatient SUD treatment and the first phase of the post-discharge period. SUD refers to use disorders connected to one or several psychoactive substances, including illicit drugs, prescription medication and alcohol, and has been defined as including a damaging effect on social, environmental and psychological levels (UN, 2016; WHO, 2019). SUD treatment usually includes psychological, medical and social interventions which aim to alter destructive conditions and strengthen behaviour that reduces the above-mentioned negative consequences (Mørland & Waal, 2016). SUD

treatment involves a range of modalities and treatment intensity levels, such as inpatient or outpatient treatment, intending to cover a spectrum of different needs.

Even if people who struggle with substance use mainly achieve recovery without formal SUD treatment (Klingemann, Sobell, & Sobell, 2010; Price, Risk, & Spitznagel, 2001; Willenbring, 2010), SUD treatment has been considered as important in promoting lasting recovery (Brorson, Ajo Arnevik, Rand-Hendriksen, & Duckert, 2013; Lauritzen & Nordfjærn, 2018). People who are referred to specialised inpatient SUD treatment represent a population with multiple psychosocial challenges, who often struggle to handle their everyday lives (e.g., maintaining daily routines, attending work or other meaningful obligations) (Camilleri, Cacciola, & Jenson, 2012; Helsedirektoratet, 2015; Lopez-Goni, Fernandez-Montalvo, Arteaga, & Esarte, 2017; Norwegian Directorate of Health, 2015; Wakeman, Metlay, Chang, Herman, & Rigotti, 2017).

An important purpose of specialised inpatient SUD treatment is preparation for everyday life after discharge, and social integration into general society (Sumnall & Brotherhood, 2012). Continued care encompasses individualised follow-up services after the inpatient treatment phase (McKay, 2009), and has been recognised as an enabling factor in SUD recovery (Sumnall & Brotherhood, 2012; UNODC & WHO, 2016). Despite the recognition of specialised inpatient SUD treatment and continued care as one coherent, continuous process, SUD

services are often provided at different organisational levels in the public welfare system. The transition between service levels often serves as a barrier in the SUD recovery process (Manuel et al., 2017; Regionale helseforetak-nettverket, 2010; Sosialdepartementet, 2003). Continued care as described above is not an obvious continuation after discharge from specialised inpatient SUD treatment and *continued care* is often used as a designator for *the period after discharge* from specialised inpatient SUD treatment. In the current study the period after discharge from inpatient SUD treatment is referred to as the *post-discharge period*. While specialised inpatient SUD treatment is referred to as *inpatient SUD treatment*.

In terms of social, physiological and psychological well-being (Schulte & Hser, 2014; UNODC & WHO, 2016; WHO, 2019) there are substantial differences between a life dominated by substance use and a life that is not dominated by substance use. Maintenance of SUD recovery after discharge from inpatient SUD treatment often requires profound transformation (Manuel et al., 2017; Robertson & Nesvåg, 2018). Several factors have been highlighted as facilitating in the transformation process, such as social support (see, e.g., Bahl, Nafstad, Blakar, Landheim, & Brodahl, 2019; Brooks, Magaña López, Ranucci, Krumlauf, & Wallen, 2017; Levälähti, 2007; Pettersen et al., 2019; Soyez & Broekaert, 2003), motivation, self-efficacy, self-awareness (Eslami, Norozi, Hajhosseini, Ramazani, & Miri, 2018; Polcin & Korcha, 2015; Turpin & Shier, 2017) and predictability in basic elements such as employment, housing and personal finances (Andersson, Otterholt, & Gråwe, 2017; Kruk & Sandberg, 2013; Soyez & Broekaert, 2003; Sumnall & Brotherhood, 2012).

Facilitating factors, such as those outlined above, have been conceptualised as *recovery capital*. Recovery capital is described as individual or circumstantial features which may enhance the ability to recover from SUD (Best & Laudet, 2010; Cloud & Granfield, 2008; Duffy & Baldwin, 2013; Granfield &

Cloud, 1999; Groshkova, Best, & White, 2013). The recovery capital concept was first introduced to the SUD field by Granfield and Cloud (1999; Cloud & Granfield, 2008), which based their perspectives on Pierre Bourdieu's theory of practice (1977). As described by these authors, recovery capital attempts to capture a complex reality, which the various aspects of recovering from SUD represent.

Although the aforementioned protective factors seem to be well established facilitators for SUD recovery and social integration after inpatient SUD treatment, inpatients often report that they feel unprepared for the transition to everyday life after discharge (Andersson et al., 2017; Haugum, Holmboe, Iversen, & Bjertnæs, 2016; Haugum & Iversen, 2014; Haugum, Iversen, & Bjertnæs, 2013; Skudal, Holmboe, Haugum, & Iversen, 2017). Service level transitions represent a vulnerable point in the change processes of other populations as well. Examples of such transitions are discharge from hospital (Anthony & Hudson-Barr, 2004), discharge from shelters for people who lack a permanent home (Herman et al., 2011; Susser et al., 1997) or discharge from women's shelters (Lako et al., 2018). However, taking the increased risk of relapse after discharge from inpatient SUD treatment into consideration (Andersson, Wenaas, & Nordfjærn, 2019; Nordfjærn, 2011), the potential consequences of relapse to substance use after a period of abstinence are often severe and sometimes fatal for people with SUD (Bukten et al., 2017; Merrall, Birdl, & Hutchinson, 2013; White, Bird, Merrall, & Hutchinson, 2015). This implies that SUD treatment providers may make better use of the existing body of knowledge on protective factors in the transition and post-discharge period. For example, by integrating the knowledge of services and interventions that are established to facilitate the transition between inpatient SUD treatment and everyday life after discharge. The existing body of knowledge, however, mostly builds on participants'

experiences *after* they have completed the transition between service levels. The current study will advance the literature by examining the expectations of people *facing* a service level transition. This knowledge may contribute positively to the process of establishing facilitating services in the transition and post-discharge period. On this basis, the aim of the current study was to explore the following research question: What factors are anticipated by patients to be facilitating in the transition between inpatient SUD treatment and the post-discharge period?

## Material and methods

### *Focus group study*

A focus group study was carried out to investigate the current research question. Focus group studies consist of interviews, which refer to group conversations about a delimited theme. Focus group interviews draw on group dynamics between the participants to generate knowledge. Focus group studies are often conducted in order to explore attitudes, social interaction, negotiations, common beliefs and viewpoints (Halkier, 2010; McLafferty, 2004). Even if recommendations and practices vary markedly, focus groups normally consist of six to 12 participants (Guest, Namey, Taylor, Eley, & McKenna, 2017; Halkier & Gjerpe, 2010; Malterud, 2012).

Focus group interviews have the potential to unveil both expectations and social interaction (Halkier, 2010; Malterud, 2012). As the aim of the current study was to gain insight into expectations in a delimited group and in a certain contexts, we considered focus group interviews to be a suitable approach to gather a body of data with relevance to elucidate the research question. As the topic of interest may be considered as sensitive, we chose to draw on slightly smaller focus groups than normally recommended and aimed to form groups with six to eight participants in the current study.

### *Participants and setting*

Inpatients at four different facilities in Norway, which provided long-term (more than six months) inpatient SUD treatment, were invited and consented to take part in the focus group study. The treatment programmes at the four facilities all contained individual, environmental and group therapy, and took place at the treatment facility where the patients resided. All four facilities were administrated by private organisations, but had a contractual agreement with one of Norway's four public health enterprises which provide specialised services. The contractual agreement ensures that the facilities adhere to a set of formal requirements. Services connected to the post-discharge period varied between the four treatment facilities. One of the facilities provided shared housing for inpatients after discharge from the inpatient SUD treatment. The house was shared with other former inpatients from the same treatment programme and was administrated by the private organisation that runs the treatment facility. One facility offers follow-up appointments in the three first months after discharge. Follow-up after discharge from inpatient SUD treatment is not one of the formal requirements but was provided as an extra service from those two facilities. The two remaining facilities had no such service and relied on follow-up services provided by the municipal health care services.

All four facilities provided treatment for use disorders connected to one or several psychoactive substances, including illicit drugs, prescription medication and alcohol. However, one of the facilities primarily treated alcohol use disorder. One of the treatment facilities provided inpatient treatment for men who were aged 30 years or older. Two of the treatment facilities provided inpatient treatment for younger (aged 18 to 40 years) men and women with SUD. And one treatment facility provided inpatient treatment for men and women with SUD who were older than 20 years. In Norway, facilities providing inpatient SUD treatment that exceeds nine months

are usually administrated by private organisations with contractual agreements, such as these four facilities. The four facilities may therefore be considered as representative in a Norwegian context.

Inpatients were recruited for participation through the respective facilities' appointed contact person during the period from March to May 2018. Only patients who had completed a minimum of five months of the inpatient treatment phase, and had adhered to the same treatment programme, including group therapy, were considered as eligible to participate. They therefore presumably possessed the necessary foundation to interact and explore considerations about the context they shared, as well as the needed experience from group therapy to share challenges with the group. This was also the reason participants were recruited from long-term treatment facilities.

Even if some of the participants in the focus groups had only used alcohol, the participants' use disorders were mainly connected to alcohol and/or other substances. None of the participants were employed at the time of the focus group interview, and few reported that they went to school or did charity work at the time the focus group interviews took place. Some of the participants reported that they had attempted inpatient SUD treatment previously, but few had completed the treatment programme. Those who had previously completed an inpatient SUD treatment programme reported that they used this experience to make different choices this time.

The recruitment lead to a total of four focus groups, one from each of the four included treatment facilities, and consisted of 22 participants (19 male and 3 female). The number of participants in each focus group varied between four and eight participants, and two groups consisted of only men. Participants within each focus group lived at the same treatment facility and had adhered to the same treatment

programme for a minimum of five months before the interviews took place.

### *Interviews*

The focus groups were carried out during the last week of May and the first week of June 2018 and took place at the respective treatment facilities. The interviews were audiotaped and then transcribed by the first author using NVivo 12 Pro.

The focus groups were conducted by the first author and organised as semi-structured interviews with questions from former research on facilitating factors in the course of SUD recovery (see Appendix for interview guide). The interview guide was pre-piloted in a group of representants from non-governmental organisations (NGOs) from the SUD field, and adjusted according to feedback. The interviewer started each session by providing information about her background as a social worker and counsellor in inpatient SUD treatment, and with information about confidentiality.

The opening question presented to every focus group was: "Could you tell me something about what continued care represents for you?" Apart from the opening question, the questions were, however, not presented in a particular order. If the focus group did not discuss one of the questions from the interview guide, the interviewer addressed relevant follow-up questions to the focus group. After the first question was asked, the different groups had a similar structure regarding speech flow, natural pauses and dynamics. The interviewer got the impression that the participants were used to talking in groups and to each other. For instance, the participants provided positive and negative feedback, problematised statements that were uttered and gave each other support when sensitive issues came up, such as relapse, difficulties in close relations, betrayal or shame.

The duration of the group interviews varied in between 49 and 100 minutes. There were no substantial observed differences related to group dynamics, focused themes or social

interaction between the interviews with only male participants and the mixed-gender interviews. All the interviews, except one, were situated in a conference room where the participants and the interviewer were positioned around a table. One of the interviews took place in the same room as the participants usually attended for group therapy.

### *Ethical considerations*

The study protocol was reviewed by the Norwegian Ethics Committee for Medical Research (REK) (reference number: 2017/1531) and then approved by the Norwegian Centre for Research Data (NSD) (reference number: 56577 / 3 / AMS). The participants received verbal and written information and gave written consent for the interviews to be audiotaped and used for the purposes of research. A contact person was appointed at each treatment facility in case the interviewees needed support after participating in the focus group interview.

### *Analytic approach*

Braun and Clarke's (2006) thematic analysis was considered to be an apt strategy to explore participants' expectations and common beliefs about the theme of interest, and was therefore chosen to analyse the transcribed interview material. This analytical approach consists of six steps which have been rendered in Table 1. A deductive approach was used to identify codes and themes, and the interpretation was semantic rather than latent, meaning that the statements were not analysed with the intent of finding a deeper meaning beyond what was explicitly stated by the participants.

First, the whole interview material was processed through the first four steps of the analysis. During the first step, the analyst became familiarised with the data material through conducting and transcribing the focus group interviews. The transcribed material was then coded and re-coded during the second step. Basic features such as housing, personal finances, leisure

activity, education and employment, as well as issues related to relational and emotional aspects such as social support, predictability, loneliness, trust, cohesion, honesty and attachment emerged in the coded interview material. In the third analysing step the analyst reviewed the coded material, bearing interim themes, patterns and connections between themes in mind. During the fourth step, interim themes were reviewed considering compliance of patterns within each theme, as well as validity of the interim themes in relation to the raw data material. During these two steps it gradually became clear that the same issues were repeated, but within different contexts. The contexts were recognised as the *inpatient stay*, *transition period*, *post-discharge period* and *social relations and support*.

Second, two particular parts of the whole interview material, namely the contexts referred to as the *transition period* and the *post-discharge period*, were selected to elucidate the current research question. Common aspects of discussions within these specific parts of the whole interview material were that the participants spoke about their expectations for the transition and post-discharge period. The coded material was reviewed and organised into interim themes. The coded interview material and interim themes were re-processed throughout the analysing phases several times before the final three themes, "Belonging", "Intrapersonal processes" and "Predictability", were named and defined in the fifth step of the analytical process. Decisions throughout the stages of the analytical process were discussed between the authors at all stages. The sixth and last step in the thematic analysis addresses the reporting of results.

### *Data session*

The first analysis of the whole interview material was presented and discussed in a data session group consisting of representatives from four different NGOs from the SUD field. The purpose of the data session group was to

**Table 1.** Steps in the analytical process (Braun & Clarke, 2006).

First step	<i>Familiarise with the data material</i>	Conducting and transcribing the focus group interviews.
Second step	<i>Generate preliminary codes</i>	By coding and re-coding the whole data material preliminary codes were identified within the selected part of the data material.
Third step	<i>Searching for interim themes</i>	The coded interview material was analysed in the search for interim themes.
Fourth step	<i>Reviewing the interim themes</i>	The interim themes were reviewed, and three themes were identified.
Fifth step	<i>Defining and naming the themes</i>	The final three themes were named with quotations which appeared representative for their content from the focus group interviews. The content of the themes was fully described.
Sixth step	<i>Produce the report</i>	

examine and discuss the coded interview material and themes together with stakeholders who represented the interest of the target group in the current study.

## Findings

Throughout the analytical process, the coded interview material was organised and summarised into three main themes. The themes have been displayed in a theme-map (see Figure 1), while their content has been further outlined in the upcoming sections. The following themes emerged during the analysis: “Belonging”, “Intrapersonal processes” and “Predictability”. Distinctive perceptions expressed by the participants will be presented and accompanied with quotations from the focus group interviews. The names and gender in quotations presenting discussions between participants are fictional.

### Belonging

This theme embraces factors connected to belonging in the transition period between inpatient SUD treatment and everyday life after discharge and summarises interview material coded as *connectedness* and *loneliness*. *Connectedness* includes content such as participants’ feeling of cohesion with peers within the treatment programme, their

perceived attachment to the treatment facility and their thoughts about establishing connections in general society. *Loneliness* includes participants’ reflections about the absence of cohesion or connectedness and their expressed fear of involuntary social isolation in the post-discharge period.

Participants anticipated that social relations, which they had built up with peers and the treatment facility during the inpatient phase, would facilitate the transition and post-discharge period. Here, for instance, interviewees expressed how they consider that social relations with peers would be protective in the post-discharge period:

The four of us have been here [in the facility during inpatient treatment] together for one year. When we get out there [to the post-discharge period] we have established safe relationships with each other.

In that way you spend the post-discharge period surrounded by people you can talk to and ask for help. These are people you can talk with about mechanisms that causes you to take destructive choices.

Arguably, cohesion between peers within the facility may provide an opportunity to maintain the established relationships continuously throughout the transition and post-discharge period.

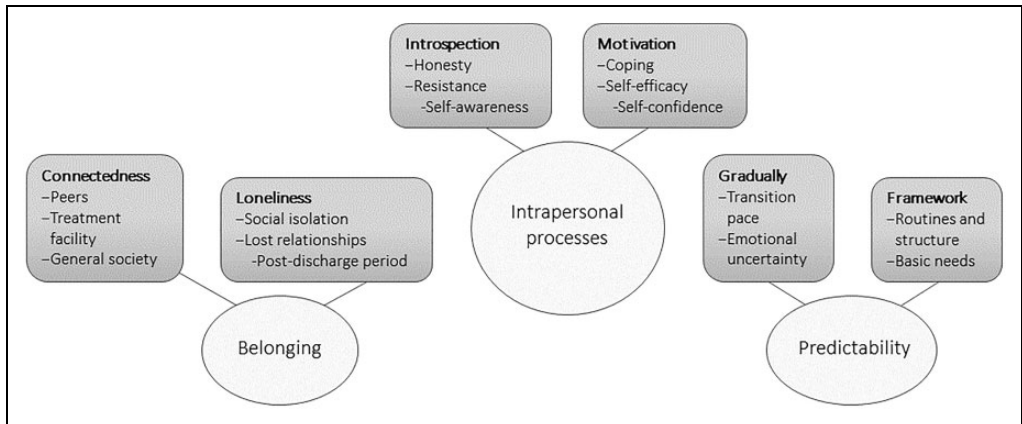


Figure 1. Theme-map.

Social relations with peers were also discussed in a wider sense, and as an aspect that depended on trust in others, as well as a factor which fostered a sense of responsibility to support other people. Similar viewpoints were echoed in several discussions across the focus group interviews. The inpatient SUD treatment environment appeared to be preserved by the participants as a suitable arena in which to practise social skills. During the interviews, social capability was, in turn, emphasised as valuable recovery capital that was expected by the participants to facilitate the transition period.

The issue of building a foundation for belonging was addressed repeatedly and brought up as a task which had to be fulfilled. A common belief was that previous friends, who still were struggling with addiction, had to be dropped and replaced in order to achieve a feeling of readiness to enter the transition and post-discharge period. Throughout the interviews, however, this was both addressed as an issue that should be solved during the post-discharge period, and as a task that should be undertaken during the inpatient phase.

Participants further discussed the function of social connectedness with people, places or leisure activities in the general society, i.e., outside the treatment facility:

Peter: I think that maybe team sport is better than joining the gym?

Kim: Yes, that is for each and one to decide.

Robert: Such as street football, which is damn good if you like it.

Peter: Yes. I think that someone is expecting you when you join team sport. Maybe someone calls you if you do not show up. A gym does not call you if you miss out. A team has some expectations of you. At least for me, I think that can be important.

In this discussion, attention was drawn to potential expectations from people in general society. The participants draw a line between the gym, where they expected that people normally train alone, and team sports, where they assumed that people interact more with each other. The interviewees then connected the distinction between these two arenas to expectations from other people and social connectedness. Discussions across the interviews about leisure activity, but also connected to the work and school environments, took similar paths. Moreover, meaningful activity, such as sports, leisure activities, school, work and skills training, was frequently emphasised as facilitating in the post-discharge period, and especially as a facilitator for social interaction with people in general society.



In contrast to a sense of belonging, loneliness was thematised:

And then you have the thing about social network, because I only had drug-friends in the end. Soo, that is something I dread. I must prepare to spend much time alone in the beginning [in the post-discharge period] and that can become tough.

This interviewee expressed her fear of involuntary social isolation in the post-discharge period. Similar worries were addressed repeatedly and foremost in discussions concerning individual housing, lacking attachment to peers, the treatment facility or the general society in the post-discharge period.

Belonging was brought up from different perspectives, such as the fear of losing relationships that had been established during the inpatient phase or in connection to involuntary social isolation in the post-discharge period. Consequently, the importance of building social relations during the inpatient treatment phase, which lasted throughout the post-discharge period, was perceived as a preventive factor against loneliness.

### *Intrapersonal processes*

This theme revolves around intrapersonal processes in the transition between inpatient SUD treatment and the post-discharge period, and summarises interview material coded as *introspection* and *motivation*. *Introspection* embraces participants' considerations about honesty, resistance and how experiences of these factors broaden participants' self-awareness. The content of *motivation* revolves around participants' experiences of coping and self-efficacy, and how these elements were anticipated to be facilitators for their self-confidence during the transition period.

Honesty towards oneself was emphasised as a necessary aspect to broaden introspection. This interviewee, for example, described how he experienced that honesty in social

interactions facilitated independence and introspection in the sense of increasing his knowledge about himself:

When you give your honest opinion about other people and reveal your observations when you meet other people, you kind of get to know yourself better also. In one way, it helps you to become able to help yourself.

Honesty was also highlighted as important to benefit from therapeutic interventions in the inpatient treatment phase, such as individual, group or environmental therapy. Furthermore, honesty was repeatedly addressed as facilitating trust and, in turn, as a valuable foundation in social relations.

Resistance against revealing honest opinion to peers was also thematised. One participant described how interfering by disclosing his honest opinions for a long time led him to feel uneasy and defiant:

I have been here [at the treatment facility] for six months now. Still, something is screaming inside me that "this is wrong!" But something is about to change. The thought of poking my nose into other people's stuff and maybe make someone feel uncomfortable by giving them my honest opinion, has made me hesitate.

Resistance was discussed as a reaction to the structure and rules provided by the treatment facility and, in a wider sense, the determined framework in general society. When honesty was discussed in retrospect, it foremost represented something negative, like snitching, and it was considered as an undesirable personal trait. Honesty was, however, recognised as a fundamental feature for achieving sustainable recovery from SUD and to integrate into general society.

Motivation was a recurring subject and was highlighted as a component that relied on other factors, such as coping and self-efficacy. For instance, this interviewee spoke about how the experience of seeing peers cope in treatment gave him motivation:

I saw it the same way; people with tough, tough background who manage to rise. That was very motivating, for me at least.

Similar standpoints, for instance how experience of peers' coping behaviour was pinpointed as influential for the observers' own self-efficacy, were echoed across the interviews.

Aspects such as coping and self-efficacy were continuously highlighted as essential to increase self-confidence and maintain motivation during the inpatient treatment phase, as well as throughout the transition and post-discharge period. Furthermore, introspection in terms of self-awareness related to honesty and emotional resistance was perceived as fundamental in order to handle major change.

### Predictability

The main topic of this theme includes predictability in the transition period between inpatient SUD treatment and the post-discharge period, and summarises interview material coded as *gradually* and *framework*. *Gradually* involves participants' views on the transition pace, as well as their experiences of emotional uncertainty connected to the upcoming transition period and post-discharge period. *Framework* concerns participants' considerations about integrating routines and structure, which ideally would have been founded during the inpatient treatment phase, into the transition and post-discharge period. Additionally, *framework* revolved around uncertainty connected to basic needs such as housing, personal finances, employment or leisure activity, in the transition and especially in the post-discharge period.

The pace and steadiness of change in which the transition progressed were highlighted as essential matters across the interviews. For instance, in this discussion, the importance of proceeding gradually to retain a feeling of security in the transition, was emphasised:

Karl: Continued care is like a carrot. When you get out there you may suddenly

have a mobile phone, watch more television and you can go to the gym every day if you want to.

Simon: Yes, but you are still surrounded by a security net.

Camilla: So, it is a gradual transition, which is much easier than going straight into society. [...] In my opinion, everybody actually needs such a gradual transition.

The idea of the value of a gradual transition pace recurred across the interviews and in reference to different contexts. For instance, a steady transition pace was addressed as important in connection to emotional change, for example in becoming emotional capable to ask others for help, strengthening one's self-confidence, increasing one's self-awareness or self-efficacy. The anticipated positive qualities of a gradual transition pace were also pinpointed in connection to aspects such as mastering personal finances, participating in building a functional structure in the upcoming post-discharge period or starting education or work:

When you get out there, it is time to start to use the things you have learned in here, like getting solid structure and routines in your everyday life [...] so that you can manage to maintain abstinence.

The treatment facility was rendered as an arena where structure and routines were provided and where this framework could be embraced, tested and modified to suit anticipated needs during the transition and post-discharge period.

Participants further uttered emotional uncertainty by indicating distrust in their own ability to carry forward the provided framework into the post-discharge period:

You can repeat the same thing over and over again, and tell yourself that "no, no, no" [...]. Eventually, you will say yes. It is not like it will be "no" for ever after you have said no to drugs enough times. You cannot train for these kind of situations [...]. You can take as many stands as

you wish up here [at the facility], I think, but [...] you still must remain on guard [after discharge].

Emotional uncertainty connected to challenges participants envisioned encountering in the transition period, was also repeated across the interviews. These statements were mostly related to how progress in the transition was dependent on the external support system.

The procedure to establish an individually modified framework, gradually and at a stable pace that facilitated predictability, was emphasised as a time-consuming operation and represented an underlying subject in several of the discussions about the transition period across the focus group interviews.

### Summary of results

As visualised in the theme-map (Figure 1), every theme was nuanced through containing similar factors. For instance, “Belonging” summarises *connectedness* and *loneliness*. *Connectedness* was brought up by the participants in connection to peers, to the treatment facility and to the general society. While *loneliness* was thematised foremost when the participants discussed the upcoming post-discharge period (and not the inpatient or transition period), as well in connection to involuntary social isolation in the post-discharge period. Furthermore, “Intrapersonal processes” summarises *introspection* and *motivation*. During the interviews, the participants connected honesty, resistance and self-awareness to *introspection*, and coping, self-efficacy and self-confidence to *motivation*. Finally, “Predictability” summarises *gradually* and *framework*. Discussions that concerned the transition pace and emotional uncertainty have been summarised in *gradually*. Basic needs, routines and structures were thematised in connection to the envisioned need for an overarching *framework* in the transition and post-discharge period.

### Discussion

The objective of this study was to explore factors that were anticipated by inpatients to facilitate in the transition between inpatient SUD treatment and the post-discharge period. Previous research is mostly based on studies about individuals’ experiences following such a transition. The findings of the current study are partly in line with findings from previous studies, but extend the literature by including insight into how inpatients envision belonging, intrapersonal processes and predictability to be facilitating factors in the transition period. Having expectations about the future, which is undecided, is opposite to articulating experiences from the past. Due to this distinction, these two perspectives contrast in how they may influence an individual’s confidence or sense of predictability in a given situation.

Social support, as a part of the theme “Belonging”, is often understood as resources in the support system, such as public services and financial aid (physical recovery capital), or as support through social relationships (social recovery capital) (Cloud & Granfield, 2008; Langford, Bowsher, Maloney, & Lillis, 1997). The current findings emphasise belonging (in terms of aspects such as accessible and positive relationships with peers, friends, family and general society), as facilitating for social recovery capital in the transition and post-discharge period. In this regard, general society refers to communities outside the treatment facility, such as the workplace, school, the local neighbourhood or the milieu around leisure activities. Furthermore, this study found that interviewees were worried about involuntary social isolation in the post-discharge period and expected this to be a distressing element in the recovery process.

In accordance with our findings, recent research on inpatients’ expectations previous to their transition from the treatment facility has emphasised social support as being essential to continue the recovery process during the transition and post-discharge period (Manuel et al.,

2017). Furthermore, these studies highlight involuntary social isolation as an inhibiting factor in the post-discharge period. In our study, however, participants argued that cohabitation in the post-discharge period was expected to be protective against involuntary social isolation, while Manuel et al. (2017) found that participants rather would live alone in the post-discharge period if they had the opportunity.

Previous research on individuals' experiences of SUD recovery has established that aspects of belonging, such as social connectedness, functioned as facilitators in the recovery process (Bahl et al., 2019; Brooks et al., 2017; Kruk & Sandberg, 2013; Levälähti, 2007; Pettersen et al., 2019). Furthermore, elements of belonging, such as involuntary social isolation and loneliness, were perceived as barriers in the transition and post-discharge period (Brooks et al., 2017). Even if these findings were based on participants' experiences and not their expectations, as in our study, they strengthen the SUD treatment providers' incentive to meet inpatients' need for belonging in the transition and post-discharge period. This may encourage treatment providers to consider the current and previous findings by facilitating belonging in support services that are provided in the transition and post-discharge period.

The current study found that participants perceived the treatment facility as a suitable environment in which to achieve belonging by forming social relationships and strengthening social competence during the inpatient treatment phase. The participants expected these factors to be facilitators in the transition period and such factors may therefore be valued as positive recovery capital. The same was expressed in connection to the process of building a new framework for structures and daily routines in the post-discharge period; the treatment facility was outlined as an apt environment to examine and establish a new way of living. Findings from the current study reveal that the participants predicted this to be a safe way to incorporate a new framework into the post-discharge period. Moreover, interviewees

emphasised how they envisioned that expectations from people in general society (e.g., expectations from people at work or leisure activity) would motivate them to maintain the structure that they had established during the inpatient treatment phase. In line with this, the framework provided by the treatment facility may be recognised as a safe starting point in the process of customising a framework intended for the post-discharge period.

Previous research on individuals' experience with SUD recovery found that participants considered abstinence from substance use as *easy* within the boundaries of the treatment facility (Robertson & Nesvåg, 2018). The treatment facility was foremost remembered as a safe domain, free from sudden and unexpected drug-triggers (Brooks et al., 2017). These findings imply that the treatment facility was evaluated as a safe environment, which, as participants in our study pinpointed, may be a suitable arena in which to establish new routines and structures, as well as a viable place to explore relational needs and social competence. Additionally, previous research on treatment satisfaction among individuals in SUD treatment found that the opportunity to influence and modify the treatment content was associated with a favourable treatment outcome (Brenner, Resnick, Ellard, Treloar, & Bryant, 2009).

The current study found that interviewees anticipated predictability, such as a gradual transition pace, would be essential to establish the emotional stability and safety they envisioned as necessary to explore new surroundings. This was also perceived as important in order to take on challenges that eventually would facilitate the process of building a sustainable framework intended for the post-discharge period. These findings are in line with earlier research on inpatients' expectations (Manuel et al., 2017) as well as research on individuals' experiences of SUD recovery (Soyez & Broekaert, 2003).

In the current study, participants highlighted intrapersonal processes, such as honesty, as foundational in social relationships. The

participants expected honesty to be a valuable element in the process of building lasting relationships that they envisioned would strengthen their prospects during the transition period. These findings are supported by previous findings that examining individuals' experiences of SUD and everyday life after SUD recovery, which imply an interdependency between social recovery capital and values such as trust and honesty, which are important values in building cultural capital (Jason, Light, Stevens, & Beers, 2014; Weston, Honor, & Best, 2018).

Furthermore, the current study found that participants expected intrapersonal processes, such as motivation, to be an influential recovery capital in the transition from inpatient SUD treatment to the post-discharge period. Motivation may be understood as the *ability*, which partly is influenced by self-efficacy, the *drive*, which can be influenced by the discrepancy between reality and desires, and the *readiness* for change (Miller & Rollnick, 2004). Participants in the current study underlined the importance of experiencing peer coping (i.e., having a role model) by linking this experience to improved self-efficacy, which in turn strengthened their motivation. Self-efficacy may be recognised as a person's confidence in their own ability to reach a goal (Bandura, 1994). In our findings, participants reported that *having a role model* strengthened their motivation. These findings are slightly different from recent research on inpatients' expectations previous to their transition from SUD treatment, which found that people who were *seen* as role models perceived increased motivation (Manuel et al., 2017; Polcin & Korcha, 2015).

Previous research on experiences of SUD recovery and the relation between treatment motivation and abstinence after discharge, found that motivation may prevent stressful situations in everyday life, and protect against relapse to substance use (Eslami et al., 2018). Motivation has also been reported to be positively associated with an improved sense of belonging, including factors such as social recovery capital and social connectedness

(Polcin & Korcha, 2015). These previous findings underpin the value of incorporating services and interventions that enable participants to remain motivated during the transition and post-discharge period.

Finally, the need for predictability in relation to basic needs that influence recovery capital, such as physical (i.e., housing, personal finances, work and leisure activity), human and cultural capital (i.e., self-confidence, security, readiness for discharge), was stressed throughout the interviews in the current study. The importance of meeting individuals' basic needs has repeatedly been highlighted as an essential aspect in the SUD recovery process. It has therefore been recommended that basic needs are addressed and met during the inpatient phase, as unfulfilled basic needs during the transition and post-discharge period seem to influence the individual's ability to recover (see, e.g., Andersson et al., 2017; Kruk & Sandberg, 2013; Manuel et al., 2017; Soyez & Broekaert, 2003; Sumnall & Brotherhood, 2012).

### *Strengths and limitations*

In this focus group study, several treatment facilities were included and the discussion in the interviews took similar paths across the four focus group interviews. The interview guide was pre-piloted. These are all aspects that contribute to strengthen the reliability of the current research findings.

The uneven distribution of gender across the focus groups may represent a limitation. However, the distribution reflects the gender composition in the SUD population (Lev-Ran, Le Strat, Imtiaz, Rehm, & Le Foll, 2013; Riley, Hempel, & Clasen, 2018).

Even if some of the participants reported that they had previously attempted inpatient SUD treatment, few of those had completed the treatment programme. People with SUD often make several recovery attempts, with or without formal SUD treatment, before they achieve recovery (Kelly, Greene, Bergman, White, &

Hoepfner, 2019; Price et al., 2001). In this context, and even if some of the participants in the current study had previous treatment experiences, our findings may be valuable in terms of meeting the target groups expected needs in the transition period. However, further research is needed to explore whether the perceived needs of those with and those without previous experiences of discharge from inpatient SUD treatment differ.

Focus group interviews may facilitate social desirability and lead participants to modify their statements to appear in a favourable manner. Additionally, the participants' statements may have been influenced by the treatment programme in which they were enrolled. During the analysis process we aimed to keep the inferences and conclusions aligned with what was stated by the group of participants and to take the group dynamics into account. Nevertheless, our findings may have been influenced by these limitations. On the other hand, participants in the focus groups had adhered to the same treatment programme, including group therapy, for at least five months and presumably possessed the necessary foundation to interact and share challenges with the group.

## Conclusions

There is limited knowledge about factors that inpatients envision to facilitate the transition and post-discharge period after inpatient SUD treatment. The current study sought to advance the literature by exploring and identifying inpatients' anticipations about such factors. Knowledge about facilitating factors may be useful for inpatient SUD treatment providers so that they can establish services that match inpatients' expectations.

Findings from the current study highlight three such overarching factors by outlining "Belonging", "Intrapersonal processes", and "Predictability" as expected facilitators during the transition and post-discharge period. Findings from our study on expectations, as well as previous findings from studies on experiences,

imply that certain aspects appear to be facilitating during vulnerable phases such as service level transitions. Arguably, these findings should be taken into consideration and used as steppingstones through the transition and post-discharge period after inpatient SUD treatment.


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## ORCID iD

Dagny Adriaenssen Johannessen  <https://orcid.org/0000-0002-8601-6534>

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## Appendix

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### **Focus group interview, inpatients' expectations**

*Preparing for the transition period between inpatient treatment and everyday life after discharge*

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Interview questions:

- Could you tell me something about what continued care represents for you?
  - How are you preparing for the time after discharge from the treatment facility?
  - How are you collaborating with your treatment team to prepare for the post-discharge period?
  - How do you experience having influence on the post-discharge follow-up service content?
  - In what way has the external support system been involved in the preparations for discharge?
  - In your opinion, what should post-discharge follow-up services contain of to facilitate a favourable treatment outcome?
  - Are there measures or interventions in the treatment programme that are helpful in coping with challenges you face on leave during the inpatient phase?
  - In what way has interventions provided by the treatment programme facilitated a feeling of readiness for everyday life after discharge?
  - How do you and the treatment facility cooperate to provide a functional external support system?
  - How do you, the treatment facility and the external support system cooperate to provide a safe and sustainable environment in the post-discharge period (i.e., housing, personal finance, work, education, leisure activity, social network, friends and family)?
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