WHEN COMMUNITIES CARE: TREATING PEOPLE WITH SUBSTANCE USE DISORDER THROUGH A MULTI-DISCIPLINARY TEAM

by

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People recovering from a Substance Use Disorder (SUD) face a myriad of physical, emotional, and psychological challenges. Parents in recovery may also face the additional burden of mandatory participation in multiple community agencies including the Department of Human Services, Community Justice Parole and Probation offices, and medical treatment. The Oasis Center of the Rogue Valley is a nonprofit primary clinic that specializes in treating parents and families who are affected by drug dependency. The Oasis Center recognizes the need for centralized care amongst parents in recovery who participate in multiple agencies. They have created a Multi-Disciplinary Team (MDT) to help coordinate care for people in recovery who participate in two or more community agencies. My research question asks: does the Oasis Center of the Rogue Valley's MDT program improve the lives of people recovering from Substance Use Disorder with their multi-disciplinary team? Structured interviews and online surveys were conducted with 14 current and past MDT participants. My analysis shows that the majority of the MDT participants who responded believed the MDT increased their chances of maintaining long-term recovery

and has improved their recovery thus far. My study concludes that the MDT helps parents in recovery and measures should be taken to increase the number of MDT's utilized to treat people in recovery.

Acknowledgements

I was raised in a community where family and friends are one in the same, where love and connection extend beyond borders, and where commitment to one another runs deeper than any political, social, or economic divide. My community is my world, and this thesis is written for them. In embarking on my final undergraduate project, I felt the need to run back to my community for strength. In that trip I found a calling towards other communities that reach out for extra support. Through this search, I landed in the waiting room of the Oasis Center, watching families try to keep their heads afloat with love, only to see them pulled under water by the fervor of addiction.

I acknowledge my privilege in this process and count my blessings each day that drug abuse does not pull my own community apart. I have spent time questioning my role in researching the world of substance use, as I myself have never suffered the consequences of an SUD diagnosis. However, I do know about community, and the critical role support plays in everyone's life. I am honored to have a seat at this table, to study the impact of Oasis' MDT program on parents recovering from SUD, and to learn how this population can be better supported by the community around them. I recognize that my role is to listen, ask questions, and hold grace for those who live in this world every day when I am able step out of the world of drug dependency when I turn off my computer, a privilege I do not take for granted.

First, I want to thank the Oasis Center staff, Kristen Johnson, Renee Dodge, and Kerri Hecox, for supervising my internship during the summer of 2020, allowing me to study their MDT program closely, and for doing such admirable work. These women are true superheroes. Many thanks to the 14 Oasis patients who shared their experiences

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Like recovery, a thesis cannot be completed in isolation. There must be people there to care for us when we are down, push us to keep going, and hold us accountable when necessary. I have learned through this process that teams build success while community holds us close; Our people are our power.

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List of Acronyms

Abbreviation	Meaning
AA	Alcoholics Anonymous
ACE	Adverse Childhood Experience
ARC	Addiction Recovery Center
CDC	Center for Disease Prevention and Control
CWS	Child Welfare Services
DHS	Department of Human Services
MAT	Medication-Assisted Treatment
MDT	Multi-Disciplinary Team
NA	Narcotics Anonymous
OUD	Opioid Use Disorder
SUD	Substance Use Disorder
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families

Chapter 1: Introduction

I met Helena[1] last summer while interning at the Oasis Center of the Rogue Valley. While meeting with Helena in a dark room for an interview with masks, face shields, and ten feet of distance between us, I asked her what the hardest part of the pandemic had been for her. Helena had been a frequent user of oxycodone for most of her adult life but made the decision to finally get sober when she became pregnant with her first child three years ago. She now has two kids with one more on the way and told me that the hardest part of the pandemic has been not being able to attend in-person Narcotics Anonymous meetings. She told me that Zoom meetings are available, but they just aren't the same. She explained that life has been hectic because her ex-boyfriend has been battling her for custody of their child, even though she knows he is still regularly using. She also doesn't have a car, is searching for a second job, her SNAP benefits have been revoked, and she is pregnant with an at-risk fetus. She told me that life is just really hard, and she constantly battles the desire to use.

In the United States alone, 128 people die every day from drug overdoses (Opioid Overdoses, 2020). For comparison, 90 people die each day from auto accidents (Fatality Facts, 2018). Illicit drug use in Oregon exceeds the national average and is ranked #4 in the U.S. for past month drug use (Northpoint, 2019). However, new treatment centers are emerging. One new treatment center is the Oasis Center of the Rogue Valley, a clinic that treats people with Substance Use Disorder (SUD) through Medication Assisted Treatment (MAT). Medication Assisted Treatment is physician-

[1] Name has been changed

prescribed medication to ease the transition off of opioids that coincides with counseling and behavioral therapy. Common MAT drugs include buprenorphine, methadone, and naltrexone. These drugs help "normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative and euphoric effects of the substance used" (Medication Assisted Treatment, 2020). In addition, studies have shown MAT treatment to significantly reduce death among heroin users and reduce cases of relapses (Schwartz et al, 2013).

The Oasis Center of the Rogue Valley is interested in treating people just like Helena. A nonprofit primary care clinic located in Medford, Oregon that specializes in treating drug-affected mothers and families, Oasis recognizes that the system is broken; that the stress of caring for children, paying rent, getting to and from court dates, working a job, finding a second job, and battling the legal system is challenging for a sober person, let alone a person who is battling drug addiction. To address gaps in how people struggling with addiction receive treatment, Oasis employs a Multi-Disciplinary Team (MDT) program. This program is different because it is a treatment plan that teams up with other community partners to address the multi-faceted challenges Oasis patients face every day, taking a more holistic approach to treatment and recovery. Two team members represent the Department of Human Services, one from the Child Welfare department, a division that ensures children live in safe and nurturing homes, and the other from the Self-Sufficiency department, the division that works with economic vitality related to employment, food stamps, and housing. A representative from Jackson County Parole and Probation, another from OnTrack (a recovery

detoxification center), one from Addictions Recovery Center, and the medical staff at Oasis all meet once a week to discuss how they can work together to treat patients and families who participate in their different systems. Providing transportation to court dates, being flexible with doctor appointments, and advocating directly to the DHS representative to help someone get back on SNAP are all examples of how the MDT functions. Oasis does not just provide its patients with medication-assisted treatment, but they help them get back on their feet with help from other community systems.

Some research has been done on the effectiveness of multi-disciplinary teams in treating other medical conditions such as cancer (Friedland, 2011, Selby et al, 2019) and diabetes (Foster, 2017), but little research has been done on how multi-disciplinary teams can treat people recovering from substance use disorders. Because of the convoluted nature of addiction and the many community systems involved in caring for those with SUD, Oasis' MDT program is innovative in the world of addiction treatment.

My thesis intends to determine if Oasis's MDT program improves the lives of people recovering from SUD and their families through the program. If it is deemed successful at improving lives, I hope my findings can help implement similar programs in other communities.

Existing Literature

The literature review will outline the existing literature around substance use disorder, with particular focus on parents and families since this is the population Oasis targets. Additionally, the literature review outlines adverse childhood experiences, and the effect adverse childhood experiences has on later health outcomes.

Substance Use Disorder in the U.S.

Substance Use Disorder, defined by Mayo Clinic, is a "disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication" (Drug Addiction, 2017). The Mayo Clinic website also explains that "you may need help from your doctor, organized treatment program, family, friends, or support group to overcome your drug addiction and stay drug free." The nature of substance use lends itself to isolation, and social interaction is key for recovery.

A study published in the Journal of Contemporary Psychotherapy explores the effect of including concerned significant others during the recovery of people suffering from both SUD and PTSD (Wanklyn et al, 2019). The study highlighted only one individual's experience with the treatment and showed a positive trend. However, the lack of this sample size limits its credibility. The impact of relationships during recovery is significant and this article vaguely discusses the positive impacts. Another limitation of this study is its choice in human subject. The person who agreed to the study identified as not having "[any] friends or family member to which he felt close" (Wanklyn et al, 2017). This isolation is common among those recovering from SUD but is not always the case. This source provides excellent scientific explanations for the benefit of social support and is useful for its definitions and explanations alone.

The impact of family support is further explored in a study published in the Journal of Addiction Medicine. Family support has been shown to "improve health outcomes for all family members, result in better addiction treatment outcomes, and

prevent adolescent substance use (Ventura, A., Bagley, S., 2017). A family-centric model is paramount to improving recovery rates for those with substance use disorders.

The impact of use disorders on families and children are explored in Lander, Howsare, and Byrne's article from a social work lens (2013). This article does a good job explaining why and how the whole family is impacted by an SUD diagnosis. However, its approach is rooted in social work, rather than public health policy. The theories described are useful, but the general tone of the article promotes individualized treatment plans for patients and families suffering from SUD opposed to the broader policy framework which speaks to my argument for an MDT program. Additionally, an article published in "Child Maltreatment" highlights the gaps in the systems that report child abuse (Child Welfare Services (CWS)) and substance abuse (substance use treatment) (Young et al, 2007). These systems do not overlap in their reporting methods, leaving individuals and families who belong to both systems underserved. This article provides opportunities to connect these two systems. A limitation within this study is that CWS only reports cases of children who have been removed from the care of their guardians and does not include cases of children who are actively living with guardians who have SUD or are on a substance treatment journey. Along with the impact of SUDs on families and children, an article from the Annals of Family Medicine gives statistics on the number of individuals with Opioid and Substance Use Disorder in the United States from 2015-2017 (Clemons-Cope et al, 2019). This source helps identify the need for greater intervention for parents with substance use disorders.

Substance use disorder among pregnant women and mothers

Though much research has been done on the effects of substance use disorder and treatment for substance use disorder (Greenfield, 2007, Klomegah, 2016, Tracy et al, 2012), very little research has been done on treatment for pregnant mothers recovering from SUD. Wesley Smith's research finds that pregnant women are less likely to complete substance treatment than nonpregnant women and that those referred by the criminal justice system are more likely to complete their treatment (Smith, 2020).

My research asks if the Oasis Center of the Rogue Valley Multi-Disciplinary Team (MDT) approach to treating parents and pregnant mothers with SUD is successful at improving the lives of its clients. The effects of substance use on fetuses, infants who are breast-feeding, and young children are significant. For example, regular use of some drugs can cause neonatal abstinence syndrome (NAS), where babies can go through withdrawal after birth, breastfeeding infants can experience the same effects of substances as their mothers, and older children most often experience the impact of substance abusing parents through strained relationships and heightened responsibilities (Substance Use, 2020, Radcliffe, 2020). Though the biological challenges presented to children of parents with SUD are severe, the relationship challenges can be even more taxing on children (Radcliffe, 2020).

Understanding the personal effect of SUD on an individual level is crucial to understanding why this disease is so harmful to those around them. An entry in the International Journal of Drug Policy explains the impact of drugs on parenting. This article encompasses a review of current literature pertaining to "the core themes of techniques of surveillance, how substance using parents become problematized, and the

biopolitics of drug use in young people" (Radcliffe, 2020). The complexities of parents with SUD are explored and a plethora of information can be extrapolated regarding the personal, political, and legal ramifications for parents who abuse drugs.

The existing literature on substance using parents and their children shows us that increased intervention is required for pregnant mothers and mothers of young children. An article by Ashley et al. claims that there is a need for "well-designed studies of substance abuse treatment programming for women" (2003). Positive correlations between women-targeted treatment and abstinence have been found including programs related to childcare, prenatal care, women-only programs, supplemental services and workshops, mental health programming, and comprehensive programming. However, most programs are not holistic and do not meet the many needs of women with substance use disorder. Research also shows that the negative effects of stigmatization are major concerns for pregnant women who seek substance use treatment, along with inaccessibility to childcare, employment, housing, and the potential confiscation of their children (Stone, 2015, Jessup, 2003, McHugh et al, 2018).

The existing literature shows us that research on substance use treatment for pregnant women is lacking. There is also a great need for understanding how information can be better shared among the systems that treat families. My research intends to fill these gaps by sharing how the Oasis Center of the Rogue Valley treats pregnant mothers and parents of young children. Further, by diving into the complexities of the Oasis MDT program, I hope to explain how information is shared between the community partners that treat the same families.

Adverse Childhood Experiences: The Next Public Health Crisis

Treating parents with Substance Use Disorder does not only benefit our current economy, health care system, and community, for Oasis patients who have children (as all MDT participants do) it is an act of preventative medicine as well. In 1998, Kaiser Permanente published a study that showed the strong relationship between adverse childhood experiences (ACEs) and adult health risks (Felitti et al, 1998). This study surveyed 9,508 adults who had completed a standardized medical evaluation to determine their general health. The categories of adverse childhood experiences that were studied included: psychological, physical, or sexual abuse; violence against mother; and living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. For children who experience more than four identified adversities such as abuse (of any kind), witnessing violence against their mother, or live with a household member who abuses substances, is mentally ill, or ever imprisoned, their likelihood of developing alcoholism, drug addiction, depression, attempting suicide, having an increased rate of smoking, poor self-rated health, and contracting sexually transmitted diseases are four to twelve times greater than children who experienced none of these adverse events. By working to include the whole family, and ameliorate the effects of drug addiction, Oasis is, in turn, working to prevent poor adult health in future generations.

In the Kaiser study, the number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. The results found that more than half of the respondents reported at least one ACE and one quarter reported greater than two ACEs. A graded relationship was found

between the number of categories of adverse childhood experiences and each of the adult health risk behaviors that were studied. People who had experienced four or more categories of childhood exposure, compared to those who had experienced none, were 4- to 12- times more likely to have health risks for alcoholism, drug abuse, depression, and suicide attempt; 2- to 4-times more likely to smoke, have poor self-rated health, have more than 50 sexual intercourse partners and sexually transmitted diseases; and 1.4- to 1.6-times more likely to experience physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The researchers found that, "the categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life for several of the leading causes of death in adults" (Felitti et al, 1998).

Adverse childhood experiences are harmful due their ability to cause toxic stress, which is defined as "prolonged activation of the stress-response system" (Preventing ACEs, 2017). Toxic stress has been shown to harm the nervous, endocrine, and immune system, and can even alter the physical structure of DNA, leading to the development of extreme health conditions later in life.

Though ACEs are often extremely harmful, they are also preventable. One of the main ways to prevent ACEs is to create and sustain safe, stable relationships and environments for all children and families. The Center for Disease Control and Prevention has developed a "suite of technical packages" to help communities provide the tools necessary to promote healthy childhood development. The CDC defines their

"technical package" as "a select group of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome" (CDC).

Technical packages have three parts: the first component is strategy, the second is approach, and the third is evidence. There are several strategies that prevent ACEs from happening, as well as strategies that mitigate the harm caused by ACEs. Research shows that ACEs can be prevented through strengthening economic support to families, promoting social norms that protect against violence and adversity, ensuring a strong start for children through education and childcare, teaching healthy relationship and behavioral skills to children, connecting youth to caring adults and activities, and intervening to lessen immediate and long-term harms (CDC). Some of the approaches outlined by the CDC include creating family-friendly policies in the workplace, public health campaigns to promote healthy relationships, legislative approaches to reduce corporal punishment, early childhood home visits, high-quality childcare, parenting classes, after-school programs, mentoring programs, and family-centered treatment for substance use disorders. Each of these approaches are evidence-based and prove to consistently reduce ACEs or reduce the harm caused by ACEs.

Caring for children goes beyond providing them with basic necessities. It takes more than clothing, food, and shelter to promote healthy development. As is evidenced by the Kaiser Permanente study, children who live with someone who abuses substances, has been imprisoned, or has a mental illness, experience similar physical harm later in life as children who experience abuse and neglect. By treating parents with SUD through family-centered approaches, providing safe spaces for children and parents to confide in similarly situated individuals, and ameliorating the effects of drug

addiction through MAT, counseling services, and using the MDT program to centralize the coordination of care, Oasis is attempting to improve adult health outcomes in future generations.

What is Opioid Addiction?

To understand the challenges behind overcoming opioid addiction, we must first understand how opioids work. To begin, imagine the most decadent, mouthwatering piece of chocolate cake placed before you. Your first response is a craving. You do not just want the chocolate cake. You need the chocolate cake. In that moment, little seems more pleasurable than diving in to the delicious, moist, gooey chocolate in front of you. When you do indulge in the sugar, sometimes the craving is satiated, but usually, you keep coming back for more. “Just one bite” turns into two, or three, or a whole other slice. Regardless of a sugar addiction, how full your stomach is, or the strength of your willpower, you cannot help but want the cake. This is because your brain is releasing dopamine.

Dopamine is a neurotransmitter that sends messages to others nerve cells telling them that this specific sensation/taste/feeling is good. Dopamine is released when we feel pleasure and create reward-seeking loops in our daily lives which is why we are motivated to seek out more of the thing we just experienced. To make science simple, we can replace the word “dopamine” with “motivation”. Without dopamine we have no motivation. There is a reason why it is hard to resist delicious food and fun times with favorite people; these experiences release dopamine, which why we always want more of what makes us feel good.

Opioids act as dopamine releasers and can increase dopamine levels up to 10 times their normal level—meaning that the joy that you feel from consuming that piece of cake is multiplied by ten. This leads to one of the most powerful experiences our brain can have. Opioids like heroin and fentanyl are chemically similar to morphine, which is originally found in the poppy plant. These drugs mimic the body's natural pain relievers and bind to receptor proteins in the brain to induce euphoria, which is why morphine is used to treat patients recovering from painful procedures like surgery. However, prolonged opioid use can alter the connections between brain cells creating memories of euphoria that trigger intense cravings and addiction. Additionally, the longer someone uses opioids to trigger dopamine release, the greater the dosage required to reach the same high, which is why it is so common to see people develop drug addiction after undergoing intense medical procedures. Once prescribed with a medication like morphine or oxycodone, the addictive nature of these prescription drugs causes users to crave higher dosages. Eventually, when a prescription runs out or the dosage is not high enough to trigger the same release, the person turns to stronger drugs like heroin and fentanyl to reach the same euphoria they once felt. Opioids can affect the parts of the brain that regulate breathing and taking too much of this drug can reduce the urge to breathe, leading to respiratory failure and then death, causing a fatal drug overdose.

If a person has been using opioids for longer than necessary and they attempt to stop taking the drug, the body releases stress hormones. These stress hormones trigger symptoms such as shaking, anxiety, pain, and intense dysphoria. Through this process (known as "withdrawal"), the body decreases the production of dopamine and

eventually one cannot produce enough dopamine to get out of bed, let alone make good decisions or nurture relationships (Opioid Addiction, 2021).

Medication-Assisted Treatment

The impact of opioids is incredibly strong, but luckily, there are ways to ameliorate the pain of drug addiction. Drugs like methadone bind opioid receptor sites, which activates the receptors slower than heroin and other opioids, allowing a gentle dopamine release. If methadone is taken as it should be, it does not cause any of the euphoric effects as heroin or oxycodone. Rather, methadone normalizes body function, brain function (including dopamine levels), and relieves physiological cravings (Medication Assisted Treatment, 2020).

Methadone is used to treat people with drug addiction though a system called Medication-Assisted Treatment (MAT). MAT is physician-prescribed medication to taper off of opioids. This treatment coincides with behavioral therapy and counseling to address the multi-faceted challenges behind drug addiction and is viewed as a "whole-patient" approach to the treatment of substance use disorders. Buprenorphine is an MAT drug similar to methadone but is less potent. Buprenorphine only partially activates opioid receptors to reduce cravings. Buprenorphine also has a ceiling for effectiveness. The effects of buprenorphine only increase up to a certain point, until it plateaus. For this reason, buprenorphine is usually prescribed to individuals with mild to moderate opioid use disorder while methadone is more common for individuals with an extremely high tolerance to opioids (Methadone vs. Buprenorphine, 2020). When used correctly, both buprenorphine and methadone were shown to cut drug-inflicted mortalities in half. MAT has been proven to be clinically effective in treating people

with opioid use disorder and drastically reduces the need for in-patient detoxification (Timko et al, 2019).

In addition to utilizing MAT drugs to treat patients, counseling and behavioral therapy plays a large role in the effectiveness of MAT. When patients receive their daily or weekly dosage of their MAT drug, they also see their counselor or behavioral health specialist. Behavioral health is defined as "the connection between behaviors and the health and well-being of the body, mind and spirit" (What is Behavioral Health, 2018). Behavioral health is different from mental health, as it is not just a person's psychological state, but also the actions (both physical and mental) that contribute to well-being including eating habits, exercise routines, alcohol consumption, relationship patterns, and more.

Community System Involvement and the Need for Multi-Disciplinary Teams

The interconnectedness of brain, body, and behavior requires community involvement beyond medical care. For people battling substance use disorders who also have young children, the need for additional support becomes clear. A brain and body battling withdrawal symptoms, social circles that promote using, and long-held habits that call for drug use all work together to keep people with drug addiction addicted. People with SUD who have children often participate in many different community systems including substance use treatment, Department of Human Services, and the community justice system. For people with SUD who also have children, their offspring, by default, participate in these systems as well. Many parents battle ex-partners for custody of their children, attend court hearings regarding probation, fight to

maintain SNAP benefits and keep their housing, all while receiving daily dosages of their MAT treatment.

A study from the University of Chicago found that of the 502,165 random families participating in their study, 23% of these families participated in multiple systems such as mental health services, substance abuse treatment, child welfare, community justice, incarceration, and food stamps. The 23% of families participating in multiple systems used 86% of these systems' resources (Goerge, 2019). They recommend that better information-sharing and cohesive structure is paramount to the success in caring for multi-system families.

Chapter 2: The Oasis Center and the MDT Program

How the Oasis Center Treats Drug-Affected Parents and Children

The mission of the Oasis Center is to transform the lives of families in recovery through integrated social and medical services. Oasis was founded by Dr. Kerri Hecox, who now serves as the primary physician and the Medical Director of the organization. Oasis serves patients by providing Medication-Assisted Treatment and primary care treatment to those recovering from SUD and their children. In addition to providing MAT, the Oasis Center supports those struggling with addiction with integrated behavioral health services, prenatal care, postpartum care, as well as pediatric care. The center also offers childcare within the space, an interactive family room for families to come together to share, learn, grow, and strengthen familial bonds, peer support through group meetings and parenting classes. Oasis also creates food security initiatives for their patients by offering weekly produce distribution, teaching gardening skills in a nearby community garden, and hosting cooking classes in their demonstration kitchen.

The MDT Program

The multi-disciplinary team employed by Oasis creates approaches for many of the strategies outlined by the CDC. For example, the Self-Sufficiency branch of the Department of Human Services supports families recovering from SUD by helping parents obtain SNAP benefits and high-quality low-income housing. The child welfare branch works to ensure a strong start for children by conducting home visits and ensuring the home-life of all children is both safe and nurturing. Finally, the Oasis

Center approaches intervention of ACEs through family-center primary care and treatment for all members of the family. The little research on MDTs in Oregon and in the United States for treating people with addiction shows that the Multi-Disciplinary Team employed by Oasis is innovative in its nature. The MDT provides support and centralized care for parents recovering from a substance use disorder. The Oasis Center was founded by Dr. Hecox in January of 2019 and the first MDT meeting with patients was on April 16, 2019.

To qualify for the MDT, a patient must:

- Reside in Jackson County
- Struggle with substance abuse/dependency (with priority placed on those with Opioid Use Disorder requiring MAT)
- Have dependent children under the age of six,
- Have an open service with at least one of the following agencies: DHS Child Welfare, Community Justice, or DHS Self-Sufficiency
- Must be able to accept responsibility for their actions and recognize that the program requires on-going participation and effort

Participation in the MDT is voluntary on the part of the client. Benefits to the client include greater coordination of services, facilitated client communication to agencies, and access to family support services.

The team currently includes:

- Oregon Department of Human Services (DHS)
- Jackson County Community Justice (Parole and Probation)

- Addictions Recovery Center (ARC)
- OnTrack, Inc.
- Oasis Center Medical Staff

Each community partner is responsible for providing treatment and care to patients/clients through their respective agencies.

Jackson County Criminal Justice (Probation and Parole)

Traditionally, parole officers have taken the role of a referee when meeting with clients, meaning that they are there to enforce rules, rather than to offer guidance. The Jackson County parole office is transitioning towards training parole officers to act as a coach opposed to a referee. Parole officers within the MDT focus on risk, needs, and barriers. They also act as community case managers and planners, work on collaborative and proactive (opposed to reactive) consequences and work to create a greater understanding of people who struggle with addiction. They recognize that people with SUD respond differently to rules than people who do not have a substance use disorder. Working with addiction specialists at Oasis, OnTrack, and ARC has helped parole officers understand how the brain of an addicted individual works and how they should work with those individuals to best prevent incarceration and create safer communities.

Department of Human Services: Child Welfare

DHS Child Welfare works to keep children in safe and supportive homes. When a child is potentially unsafe, a call is made to a hotline and the case is screened to determine if the case is in need of caseworker. Cases are screened to determine if there

is present danger and/or impending danger for the child. For DHS to file for custody of a child, danger must be imminent, lack of control must be apparent, the child must be vulnerable, the threat is observable, and the severity is great enough. DHS works to keep children in their homes as much as possible but prioritizes placing children in safe homes. DHS Child Welfare is an essential agency within the MDT. The DHS Child Welfare department offers the MDT the lens of risk management and fellow agencies are able to broaden the perspective of the caseworker, allowing caseworkers to see a fuller picture of each child and their family. They have found that when they work with parents involved in the MDT there are better outcomes for both the children and then parents, children are healthier, and families are kept together more often than not.

Department of Human Services Self-Sufficiency

The Self-Sufficiency branch of DHS provides monetary assistance in the form of grocery benefits to individuals and families who qualify. TANF (Temporary Assistance for Needy Families) works to alleviate poverty and hardship for families by providing monthly grocery benefits. TANF recipients must participate in at least 20 hours a week of paid work (established by DHS), attend peer support groups, develop a network, and work on goals related to stable housing, education, permanent employment, and job skills. Childcare is also provided for parents currently receiving TANF and while transitioning off of TANF and into more stable employment. SNAP benefits are provided to families and individuals with slightly higher income levels. Participants do not need to have children to qualify for SNAP as they do with TANF. All MDT participants who receive TANF benefits work with an MDT specific life coach to keep track of their benefits and employment status.

Addiction Recovery Center and OnTrack:

Addiction Recovery Center (ARC) and OnTrack are primary addiction resources in Jackson County. Both organizations provide counseling, treatment, and education to people recovering from a substance use disorder. ARC serves primarily people with Opioid Use Disorder (34% of all patients), those with alcohol dependency (36%), and people with methamphetamine dependency (24%). ARC provides an impatient medically monitored detox service where the average stay is 5-7 days, residential services where the average stay is 30-90 days, and outpatient services that include community family court, recovery outreach court, DUI classes, domestic abuse awareness programs, gambling treatment, and co-occurring mental health services.

Information Sharing

Team representatives that comprise the MDT meet weekly to discuss MDT participants, set goals, and problem solve. These meetings usually last approximately four hours and attendance is crucial to keep the team running smoothly. The team is successful when all agencies reach a consensus regarding each individual patient. Team members must communicate the individuals' challenges, successes, upcoming barriers, and relational changes for the team to understand how they can best help the individual patient. The team meets with each patient either once or twice a month to discuss how the team can best support the individual. Confidentiality concerns prevent the team from keeping paper records so face-to-face communication is essential.

How the Program Works

For an MDT participant to successfully graduate from the program, they must complete different stages of advancement. Below is an outline how the program operates from start to finish as it is written in the MDT manual:

Treatment Entry

It is expected that all Oasis Center MDT participating clients engage in formal substance abuse treatment. Entry into the MDT program requires patients to have completed a full alcohol and drug assessment and have enrolled in recommended/appropriate level of treatment. Oasis MDT does not stipulate which treatment provider a client is to engage with and will respect a client's right to choose their treatment provider. Clients may change treatment providers if they so choose. Agencies with whom they are involved (Child Welfare, Community Justice) may have individual requirements for certain treatment providers outside the scope of the Oasis MDT.

Phase Advancement

The Oasis MDT program uses a system of phases through which participants will progress during their time with the MDT. The length of time spent in each phase is determined by the MDT team and depends upon the behavior and performance of the participant. Participants may be moved back and forth through the phases as necessary. Phase advancement is indicated by staff at the MDT, and completion of required activities on the participants' part that are specific to the mandates of individual agencies.

Stabilization

The introductory/stabilization phase lasts at least 30 days. During this time, the participants have an initial goal-setting meeting with MDT. MDT will staff participants weekly, have at least one meeting per week if in outpatient treatment, maintain verified sobriety for 30 continuous days, and make appropriate progress according to the expected target behaviors.

Active Recovery

The active recovery phase is variable and expected to last from 60 to 120 days. During this time, participants have at least one face-to-face meeting with MDT to review progress toward goals, goals adjustment, and discuss barriers to recovery. Recommendations on meeting frequency/monitoring will be decreased or increased as appropriate based on the participant's demonstrated sobriety or relapse to substance use.

Relapse Prevention & Reintegration

The relapse prevention and reintegration phase is where the participant actively reconnects with their community, be it through employment, returning to school, or completing a community project. During this time the participant will be expected to meet at least once face-to-face with MDT to review goals and barriers. MDT staffing frequency will decrease as appropriate. Client will work actively with MDT on support and relapse prevention plans anticipating events such as closure of Child Welfare cases, termination of probation, etc.

Aftercare

Support for clients is considered “aftercare” once they have passed seminal events such as the closure of a Child Welfare case or termination of probation. Clients continue to receive on-going support services through Oasis such as primary care and MAT, child development opportunities, and informal care management with the MDT coordinator. These services are available to the client for as long as they choose to access them.

Setting and Achieving Goals

The Oasis MDT uses a system of targeted reinforcements to motivate and support clients in achieving their goals. The participant and the MDT coordinator meet and establish target behaviors on a regular basis. Target behaviors change as the participant moves through the program. Clients are provided a menu of recovery and family building activities to choose from and an Oasis logbook for recording activities. Recognizing that participants vary in their abilities, and that some encounter special barriers to their progress, this system provides guidelines but allows for flexibility.

Sample Goals Set for Participants

- Obtain or possess a valid driver’s license, if eligible;
- Seek and/or maintain employment;
- Earn a GED or High School diploma;
- Secure safe, drug free, independent housing;
- Engage in child development play groups
- Attend parenting classes

- Demonstrated sobriety;
    - 90 days
    - 180 days
    - 1 year
    - 2 years
- Complete drug treatment

Incentives Protocol

Initial Program Participation

- Clients may choose to enroll child/children in Oasis subsidized childcare, depending on availability of placements
- After completion of five approved activities (such as attendance at child developmental playgroups, parenting classes, cooking classes, NA/AA attendance, etc.) client may choose from incentive basket for a prize

Active Recovery

- On completion of 60 and 120 days documented sobriety clients may chose gift certificate of choice
- Completion of every 20 approved activities clients may choose from incentive basket

Relapse Prevention

- Clients meet with full MDT to discuss accomplishments, certificate of personal goal completion given

- 180 days documented sobriety and regular attendance at recovery and family building activities earns larger incentives

Chapter 3: Methods

To answer my research questions, I conducted in-person interviews and Qualtrics surveys (asking the same questions). The survey and interview participants were asked about the most helpful part of the MDT and how participation in the MDT has influenced respondent's relationships with the individual agencies. Those who took the survey gave much briefer responses than those who completed the interview. I provided surveys to Oasis patients currently participating in the MDT (11 people) and Oasis patients who graduated from the MDT within the last year (3 people). The sample size of survey and interview respondents was relatively small due to low levels of participation in the program currently. Only 11 people currently participate in the program and I was able to receive responses from all 11 people. I also interviewed three people who are graduates of the program out of the 13 total graduates.

Electronic and paper copies of the survey were made available to current MDT participants and graduated participants through the Oasis Center. Paper copies were available in the waiting room along with a QR code to access the electronic survey. All paper surveys were completed in the Oasis Center waiting room. Once the survey was completed, the paper form was taken to the front desk and immediately placed in a secure manila folder. I collected paper surveys from the Oasis Center, transferred the information from the paper surveys to my encrypted hard drive, then shredded the paper copies. All electronic surveys were completed at the participants' convenience.

Nine of 12 questions I asked required a yes or no response, 2 questions required an open-ended response, and my final question asked if participants had anything else they would like to share. I took the total number of "yes", "unsure" and "no" and found

the percentage of participants who responded each way to find the percentage of people who agreed, disagreed, or were unsure about the questions asked.

In addition to the 12 questions everyone was asked, the three graduates of the program were asked additional questions related to their experiences with DHS Child Welfare, Jackson County Parole and Probation, and Oasis services post graduating from the program, and were asked about their opinion of mandatory participation in the program.

Additionally, for one week I visited the Oasis center and conducted in-person interviews to obtain more in-depth answers. All surveys and interviews were incentivized with $25 electronic visa gift cards. I conducted the interview with MDT participants in a back room of the Oasis Center and recorded their responses with a voice memo which was then put onto my encrypted hard drive and deleted off my phone. These surveys and interviews were meant to better understand how the MDT functions and how beneficial the MDT has been for recovery from substance use disorders. Interviews lasted between five to fifteen minutes depending on how much information the participant wanted to share. Then narratives were extracted from these interviews to create a more holistic perspective on how the MDT works.

After completing interviews and reading survey responses, I conducted content analysis to extract narratives from the responses. Two questions asked required a free response answer. For the first free-response question: “What has been the most helpful part of the MDT?” two key phrases emerged: “increased support” and “agencies working as a team”. I counted the number of times each of these phrases were mentioned to create the narrative. For the second free response question: “How have

your relationships with the individual agencies changed since joining the MDT?", two key phrases emerged again: "increase in trust" and "lack of judgement". Again, I counted the number of times each of these phrases appeared in order to identify a narrative that runs throughout the free response questions.

Chapter 4: Results

Quantitative Data

First, I analyzed the survey data where participants were given multiple choice answers. To understand how the MDT compares to other rehabilitative treatment methods, I asked participants if they had participated in other treatment models prior to joining the MDT. 86% of respondents had participated in prior treatment (Figure 1). Though I did not ask what type of treatment respondents have participated in, knowing that there was no literature on any other MDT programs in the state of Oregon, I was able to differentiate between the MDT model and treatment models of other varieties.

Quantitative questions from the surveys and interviews asked about how the MDT has improved respondents' recovery and their feelings towards their participation in the MDT. 86% of participants felt like the MDT helped their recovery and felt the MDT improved their chances of maintaining long-term recovery. 14% of participants were unsure if the MDT has helped their recovery and the same 14% stated they were unsure if the MDT improved their chances of maintaining long term recovery. One participant filled out a survey and did not elaborate on why they felt unsure. The other participant who felt unsure claimed in their interview that, "they were supposed to help me get all this stuff together, but I've had to do it all myself and they have not helped me do anything."

All respondents claimed that having coordinated care amongst their agencies was very important to them and the vast majority (93%) said that they would recommend the MDT to other people in recovery. One person (the same respondent

who was unsure if the MDT had helped their recovery or improved their chances of maintaining long-term recovery) said that they were unsure if they would recommend the MDT claiming, “Maybe [I would recommend it] after it’s improved a little bit, and maybe it’s different for other people but just in my case, I’ve had a hard time.”

Respondents who had graduated from the MDT (three participants) were asked about their new experiences with Jackson County Community Justice, Department of Human Services, and the Oasis Center. No participants had been incarcerated since graduating or had any new child welfare cases since graduated. All three participants have stayed engaged in Oasis services since graduating (Figure 3).

Qualitative Data

For the question, “What is the most helpful part of the MDT?”, two main themes emerged. Respondents’ main answers were “Agencies working as a team” and “Increases support”. Through deciphering written and spoken responses, “agencies working as a team” was mentioned 9 times throughout the 14 responses, and “increased support” was mentioned 10 times throughout the 14 responses. There was a lot of overlap between the two themes. As one person elaborated,

> “[The most helpful part of the MDT] is having everyone work as a team and having consistent goals that they all want me to accomplish. Whereas before I would make goals with my PO and then my [DHS] caseworker would have things she would want me to accomplish. [Outside of the MDT] they’re not necessarily in conflict but it’s hard as a client of all these people to prioritize these goals. What do they want me to do first? What’s most important? And unless they say the same things, there will end up being a lot of things to do and it can be overwhelming for someone early in recovery. Just brushing your teeth and getting to a meeting is a big deal. But with the MDT they all know what goals you are working towards and they have all these reminders. It’s just really supportive.”

Another example that reinforces the theme of "agencies working as a team" is, "the most helpful part was them meeting together and me not having to run around to each and every one of them. I was able to communicate with one agency and it got passed on to the rest if it needed to be". Some of them also discuss the support gained to help them be successful:

> "Them all being together at the same time and checking in with me to see what I need and how I can be successful. I have a lot of history with my probation and stuff like that and they make sure I stay on top of everything all at once. They are always there to help me".

Other participants who took the survey did not elaborate as much in their answer but had responses such as, "their support, willingness to help you, and having all the entities in one office is great".

An additional way the MDT increased support was through the offering of resources. The word "resources" was mentioned four times and is evidenced here, "Not only did having all these people in one place help save my life but having access to the resources provided by these agencies as well."

When asked how participants' relationships with the community agencies had changed since joining the MDT, the most frequent phrase was "increase in trust" and "lack of judgement". Among all the responses, the word "trust" was used 6 times, [lack of] "judgement" was used 5 times, and "support" was used 3 times. Out of the 14 respondents, 12 of them said that their relationships with the agencies had improved since joining the MDT in some way. One respondent's answer claimed,

> "[My relationship has] improved with probation for sure. It's helped me build a better trust and I can be more honest with my probation officer when before I felt like I couldn't be honest with him because if I was honest, I would just be put in jail. Now I don't worry about that, it's

> much easier to be honest. Like, when I relapsed, I was able to tell my PO and before I would have never, ever told him for fear that he would put me in jail."

Similarly, someone said, "My relationship with Oasis has always been good and now my relationship with my PO is just amazing. He never judges me, he helps me through things, and I'm able to be honest with him no matter what". This response speaks to an increase in support from their PO and a lack of judgement.

Main Themes and Takeaways

In summary, 86% of participants had positive things to say about the MDT program. 2 people (or 14%) were unsure if the MDT had improved their experience with recovery and no participants felt like the MDT worsened their experience with recovery. When answering free-response questions, two narratives emerged when asked about the most helpful part of the MDT. Participants felt like "agencies working as a team" and "increased support" were the most helpful elements of the MDT. When asked about how their relationships with agencies have changed since joining the MDT, two narrative emerged again with participants feeling like the MDT "increased trust" and created a "lack of judgement".

Of the 14 participants, only 2 (14%) of them did not have overwhelmingly positive things to say about the MDT program. These two participants did not provide much additional information as to why it was not helpful. Even so, they did cite the resources and the support from their PO as being the most helpful part of the MDT. Only one respondent was unsure if they would recommend the MDT to other people in recovery, everyone else said they would recommend the MDT to other people. Some respondents used language like, "absolutely", "I already have [recommended the

MDT]", "Of course, yes, 100%" and "absolutely I would recommend it. This program saved my life. I've been through other programs before, and I really think in the long term they have helped me more than any other program". The main takeaways are very positive for the MDT program as is evidenced in the data collection and patient testimony.

Chapter 5: Discussion and Conclusion

The Research Question

My research question asked if the Oasis Center of the Rogue Valley improves the lives of patients recovering from SUD through their multi-disciplinary team. Based on the existing literature, most treatment options do not provide the level of support necessary for pregnant women and new mothers recovering from SUD, nor is there any information on how MDTs can be used to treat people recovering from SUD. Additionally, the lack of coordinated care among community agencies for multi-system families creates additional burdens for parents with young children and pregnant mothers recovering from SUD. My research asked if the MDT's coordination of care is successful in improving the lives of multi-system families who are in recovery.

Importance of the Findings

Based on the results of survey and interview data, the Oasis Center's MDT improves the lives of parents recovering from SUD. The vast majority of participants are pleased with their experience in the MDT. 86% of participants claim that the MDT helps their recovery and 86% believe that the MDT improves their chances of maintaining long term recovery. Based on the MDT program's success with parents recovering from SUD, similar programs should be implemented in other medical facilities that administer medication-assisted treatment to those in recovery who also participate in two or more community agencies.

Contribution to Existing Literature

My results support the findings by George, 2019, Smith, 2020, and Ventura, 2019 showcasing the MDT's effectiveness at providing interagency communication among multi-system families, creating an innovative treatment option for pregnant women, and providing family, peer, and professional support to participants. I also found that the MDT program encourages trust.

The MDT program is specifically designed to care for multi-system families to ensure that no parents or children fall through the cracks. A University of Chicago study found that "interagency communication, better information-sharing and cohesive structure is paramount to the success in caring for multisystem families" (Goerge, 2019). The MDT program requires all agencies to communicate with each other to ensure both parents, children, and society are out of harms' way.

Research shows that pregnant mothers are less likely to complete treatment than nonpregnant mothers (Smith, 2020). Additionally, those referred by the criminal justice system are more likely to complete their treatment than those who have not been referred by the criminal justice system (Smith, 2020). The Oasis MDT works directly with pregnant mothers and parents of young children. Since the criminal justice system is part of the MDT, mothers are referred by this system at high rates, showing that these mothers will complete treatment at high rates. Though pregnancy status was not explicitly asked, a few of the participants were pregnant when interviewed.

MDT program's family-centered approach to treatment allows parents recovering from SUD to include their greatest support networks, improving their chances of maintaining long-term recovery. Research shows that family and peer

support is paramount for the success of those recovering from substance use disorders (Wanklyn et al, 2017; Ventura, 2017). By including just one significant person in someone's recovery, chances of maintaining long-term recovery are improved (Wanklyn, et al, 2017). Though not explicitly asked in interviews, increased family and peer support was mentioned throughout the interviews and cited as an important component of recovery, and an important piece of the MDT through peer support groups and including the whole family in the MDT process. The emphasis on family involvement, peer support, and support from agencies make the MDT unique in its recovery tactics.

Research shows that those recovering from SUD require increased community support to maintain long term recovery. Additionally, parents of young children and pregnant mothers face additional barriers to maintaining long term recovery when they are involved in multiple community systems. Research also indicates that better studies and treatment methods are necessary for future treatment for this population. The Oasis Center's MDT program works to combat all three of these issues by providing community support, creating interagency communication, and designing a unique treatment plan that specifically aims to treat parents of young children and pregnant mothers.

Alternative Explanations of the Findings

Due to the study's small sample size, its findings could prove insignificant in a larger sample size. There is the possibility that Oasis' MDT program is successful due to other variables not controlled for in this study. Possible explanations of the success of the program could be strong interpersonal relationships with staff members amongst the

MDT and within the Oasis Center. It is possible that the individuals who comprise the MDT are likeable and care more about their clientele than most agency representatives. There is a possibility that if this program were implemented in another clinic that did not prioritize interpersonal relationships, the MDT would not be as successful.

Limitations Within the Study

Again, the small sample size limits this study's credibility. However, a larger sample size is not possible from this particular MDT since all current MDT members participated in the study. This study did not include more graduates of the program. There are 13 total graduates of the program and only three graduates were interviewed. Additionally, four total people quit the program before graduating. A more thorough study would include responses from these four individuals, but unfortunately, making contact with them was not possible in this study.

Another limitation of this study is sampling bias among the people who participated. All current MDT members were interviewed but only three out of thirteen graduates were interviewed or surveyed. There is sampling bias among the three graduates who participated. I could not account for the graduates who either chose not to participate, were not in the office during the week interviews were conducted or did not read their email about the survey.

Selection bias among those who enter the MDT must be cited as a limitation. Because participation in the MDT is optional, the MDT process may be systematically different than it would be if participation were required. There is a possibility that all MDT members are extra motivated to sustain their recovery since the program is

optional. If participation were required for all Oasis patients, the program could have very different results.

Additionally, this study took place during the COVID-19 pandemic. There is a possibility results would vary if this study were not conducted during a global pandemic. However, many Oasis doctor visits still took place in-person during the pandemic. There is no way to know how much the pandemic impacted the lives of MDT participants, but we do know that the pandemic increased overdose rates throughout the country (Linas et al, 2021).

Conclusion

As one of the leading causes of death in the United States, finding innovative treatment methods for parents of young children and pregnant women is an essential component to combatting the opioid epidemic in the United States. The Oasis Center's MDT program meets people in recovery where they are, makes lives easier, and supports people in recovery through combining community agencies to provide coordinated care to multi-system families. After conducting interviews and collecting survey results, it is clear that the majority of who have participated in the MDT find the program to be helpful to their recovery and improves their chances of maintaining long term recovery (84% of respondents). Participants cited "increased support" and "agencies working as a team" to be the two most helpful components of the MDT. Participants also stated that their relationships with the individual agencies have improved due an "increase in trust" and "lack of judgement". These responses show that the MDT is successful in treating the majority of its current participants in their recovery from SUD.

Future Work

Further research is needed on this subject to evaluate the effectiveness of an MDT program for people in recovery. Further research should include a sample group that is placed in the MDT and a placebo group that is not placed in the MDT to evaluate how helpful the MDT is in sustaining recovery. Furthermore, additional questions could be asked regarding pregnancy status and past experience with treatment to determine how successful the program is for pregnant mothers specifically and to determine how this treatment model differs from other treatment models. Due to the innovative nature of this treatment model, additional research is necessary to expand upon the effectiveness of multi-disciplinary teams throughout medical facilities. Because the Oasis Center is a small clinic serving a small group of individuals, expanding this program to larger cities and analyzing the effectiveness in different settings will be crucial to understanding how to implement this program in other areas.

Additional research regarding the economic impact of the Oasis MDT program would be beneficial for future policy implementation. In addition to personal testimony, data from Jackson county jails, emergency rooms, litigations, court procedures, the foster care system, and probation and parole spending would help tell a more complete story of the true cost-savings of the MDT program. By preventing incarceration, ER visits, DHS Child Welfare cases, court visits, and more, the Oasis MDT program is saving large amounts of community spending. A more complete study would gather data regarding these agencies and the amount of money saved by 14 people (my sample size) not participating in these entities.

Interview and Survey Questions

For MDT participant:

1. How long have you participated in the MDT?
    - Less than a month
    - 1-6 months
    - 6-12 months

2. Do you feel like your involvement in the MDT has helped your recovery?
    - Yes
    - No

    If it has helped, please tell us in what way? ____

3. Have you been in substance use treatment before?
    - Yes
    - No

    What were some of the challenges of staying sober after treatment? ____

4. Do you feel like the MDT improves your chances of maintaining long term recovery?
    - Yes
    - No

    In what way? ____

5. Has it been helpful to have your DHS caseworker, your probation officer and other professionals involved in your life talking to each other and meeting with you as a team?
    - Important
    - Somewhat important
    - Neutral
    - Somewhat unimportant
    - Unimportant

6. In your opinion, what is the most helpful part of the MDT? ____

7. How many child welfare cases have you had?

8. If you are on probation/parole, for how long have you had supervision and have you been on probation before? _____

9. Do you get TANF or SNAP?
    - Yes
    - No

10. How has your participation in the MDT influenced your experiences with these agencies? ____

11. Would you recommend the MDT to other people in recovery?
    - Yes
    - No
    - Maybe

12. Do you have a personal experience with the MDT you would like to share? ____

For graduated MDT patient:

1. How long did you participate in the MDT?
   - Less than a month
   - 1-6 months
   - 6-12 months

2. Do you feel like your involvement in the MDT helped your recovery?
   - Yes
   - No

   If it helped, please tell us in what way? ____

3. Had you been in substance use treatment before participating in the MDT?
   - Yes
   - No

   What were some of the challenges of staying sober after treatment? ____

4. Do you feel like the MDT improved your chances of maintaining long term recovery?
   - Yes
   - No

   In what way? ____

5. Was it important to you to have your DHS caseworker, your probation officer and other professionals involved in your life talking to each other and meeting with you as a team?
   - Important
   - Somewhat important
   - Neutral
   - Somewhat unimportant
   - Unimportant

6. How did your participation in the MDT influence your experiences in with these agencies? ____

7. Since graduating from the program, have you had any new child welfare cases? ____

8. Since graduating from the program, how many days have you been incarcerated? ____

9. Do you get TANF or SNAP?

   - Yes
   - No

10. In your opinion, what was the most helpful part of the MDT? ____

11. Had you been mandated to participate in the MDT do you think your experience would have been as successful?
    - Yes
    - No
    - Unsure

12. Since graduating, have you stayed engaged in Oasis services?
    - Yes
    - No

13. Do you feel like you could reach out to your MDT coordinator or someone at Oasis if needed?
    - Yes
    - No

14. Would you recommend the MDT to other people in recovery?
    - Yes
    - No
    - Maybe

15. Do you have a personal experience with the MDT you would like to share? ____

Tables

Prior Participation in Rehabilitative SUD Treatment

	Yes	No	n
Have you participated in prior treatment?	**86%**	**14%**	**14**

Figure 1

MDT's Effect on SUD Recovery

	Yes	Unsure	No	n
Do you feel like the MDT helped your recovery?	**86%**	**14%**	**0%**	**14**
Do you feel like the MDT improved your chances of maintaining long-term recovery?	**86%**	**14%**	**0%**	**14**
Is coordination of care very important to you?	**100%**	**0%**	**0%**	**14**
Would you recommend the MDT to other people in recovery?	**93%**	**7%**	**0%**	**14**
Had you been mandated to participate in the MDT, do you think your experience would have been as successful?	**33%**	**66%**	**0%**	**3**

Figure 2

Involvement in Agencies for Graduated Participants

	Yes	No	n
Have you been incarcerated since completing the MDT?	**0%**	**100%**	**3**
Have you had a new child welfare case since completing the MDT?	**0%**	**100%**	**3**
Have you stayed engaged with Oasis services since completing the MDT?	**100%**	**0%**	**3**

Figure 3

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