

# Barriers & Incentives for Adoption of EBTs

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# IOM Report: Bridging the Gap Between Practice & Research

- ◆ Structural
- ◆ Financial
- ◆ Educational
- ◆ Stigma
- ◆ Policy

Lamb, S., Greenlick, M. R., & McCarty, D. (1998). *National Academy of Sciences, Inst of Medicine, Div of Neuroscience & Behavioral Health*. Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment. Washington, DC: National Academy Press.

# Structural

- ◆ Develop in response to directives and regulations of funding & certifying bodies.
- ◆ Examples:
  - Billing for couples & family therapy,
  - Lack of medical staff in outpatient programs.

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# Financial

- ◆ Public services are under-funded.
- ◆ Private third party payment is highly restricted.
- ◆ Each payer has requirements that influence the services provided.
- ◆ Practice may be developed to access resources rather than to address specific clinical needs.
- ◆ To maintain resources programs may avoid controversial treatments (contingency management, methadone).

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# Educational

- ◆ Awareness of a treatment is an essential but not sufficient condition for adoption.
- ◆ Although the dichotomy is outdated the treatment workforce has historically been divided between recovering & academic backgrounds.
- ◆ Therapist trained “on the job” are less likely to have training in or access to information on EBTs.
- ◆ Even when motivated to adopt EBTs access to adequate training remains a challenge.

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# Stigma

- ◆ Substance abuse field has a unique burden of stigma.
- ◆ This can be seen in the NIMBY phenomena.
- ◆ Notable lack of advocacy groups such as those for other illnesses: American Heart Association, American Cancer Society, and the American Lung Association.
- ◆ These organizations can raise funds, influence policy makers, and educate consumers.

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# Public Policy

- ◆ Differs from other illnesses.
- ◆ May be justified on public safety rather than public health basis.
- ◆ Costs evaluated relative to incarceration rather than improvement in quality of life.
- ◆ Policy often influenced by public opinion rather than empirical evidence (example ban methadone and offer detoxification).

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# Incentives

- ◆ Policy Incentive
- ◆ Prestige of offering state of the science treatment
- ◆ Intrinsic motivation to do the best possible job



# Oregon Policy Incentive



- ◆ 75% of state funded programs must be EBTs by July of 2009.
- ◆ Has created demand for training in EBTs.

# Prestige

- ◆ Training and research in EBTs often gives providers exposure to the innovators of a treatment.
- ◆ Funding and regulator bodies may give favorable recognition to earlier adopters of EBTs.



# Intrinsic Motivation

- ◆ Providers are in the business of helping people.
- ◆ Clinicians want to provide the most effective treatment.
- ◆ When a treatment works, providers are exposed directly to those results.

# Behavioral Couples Therapy: A Case in Point

- ◆ BCT is a very well supported AOD treatment in the empirical literature.
- ◆ Despite strong empirical support it has not transferred to community treatment programs.
- ◆ Fals-Stewart & Logsdon reports on 5 community-based substance abuse treatment programs that conducted BCT in one or more efficacy trials.
- ◆ Five sites were revisited 3 to 5 years after conclusion of the trials.
- ◆ Recorded comments from questionnaires, medical-chart reviews, and open ended interviews.
- ◆ 4 of the 5 were no longer using BCT

Fals-Stewart, W. & Logsdon, T. (2004) Diffusion of an empirically supported treatment for substance abuse: An organizational autopsy of technology transfer success and failure. *Clinical Psychology: Science and Practice*, 11 (2), 177-182.

# Patient Level Barriers

- ◆ “Why would I want my wife involved....”
- ◆ “...my wife and my counselor would just gang up on me...”
- ◆ Where BCT failed it was:
  - Offered as one of several competing options,
  - Offered early in treatment (intake session),
  - Not offered again later after rapport was developed.

# Patient Level - Success

- ◆ “We did the assessment interviews together and it wasn’t too bad, so we just kept going.”
- ◆ Patients were informed that spouse or other family member involvement is “strongly suggested.”
- ◆ Supervisors required that assessments include patient and intimate partner whenever possible.
- ◆ BCT offered to both partners as a choice after psychosocial intake assessment is complete (four sessions).
- ◆ This stepped engagement results in a 80% engagement rate.

# Counselor Level Barriers

- ◆ “Never heard of it. What does BCT stand for, anyway.”
- ◆ Extensive staff turnover.
- ◆ In one clinic, none of the providers remained after 3 years.
- ◆ BCT trained staff who left positions often also left the field.

# Counselor Level Barriers

- ◆ “We continued to use BCT for a short time with patients who seemed to really need it, but it just didn’t seem to work anymore, so we eventually dropped it.”
- ◆ Records revealed strong negative-couple selection bias.
- ◆ Reserved for only highly distressed couples.

# Counselor Level Incentives

- ◆ “BCT works and, honestly, it is interesting to do something other than 12-step all day long.”
- ◆ The clinic that continued BCT;
  - Generally effective,
  - Increased client retention & attendance,
  - Added variety to their work routine.
- ◆ The program had very low counselor turn-over in 5 years.
- ◆ Newly hired counselors were trained in BCT by experienced staff.

# Supervisor Level Barriers

- ◆ “I think relationship work should be initiated after 1 year of complete sobriety. Then BST might be appropriate.”
- ◆ In 2 of 4 programs that discontinued BCT supervisors had changed.

# Supervisor Level Incentive

- ◆ “I am trained in the model, it helps with attendance and retention, and I require everyone be trained in BCT and use it. It is a unique service only we provide in town, which helps us in the market.”
- ◆ Supervisor had been a provider in the trials and later promoted.
- ◆ Responsibilities not only clinical but also, patient recruitment, census, attendance (billable hours).
- ◆ Clinical records indicate BCT patients attend sessions at a higher rate than individual and group patients.

# Administrative-Level Barriers

- ◆ “We stopped using BCT because we couldn't find a way to bill for it. Simple.”
- ◆ Third party payers generally unwilling to pay for couples therapy.
- ◆ BCT is typically provided over 12 conjoint sessions, often also with individual and group treatments.
- ◆ When the grant money left so did the treatment.

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# Administrative-Level Incentives

- ◆ “We educated our third-party payers about BCT before you left and now get reimbursed for these sessions. In fact, because the BCT sessions are so well attended compared to our other services, it’s a money-maker for us...”
- ◆ The CEO supports the treatment largely on economic grounds.
- ◆ They met with third party payers and also local political leaders who provided letters of support.



# Maryhaven Buprenorphine Adoption



# Why Participate in This Trial?



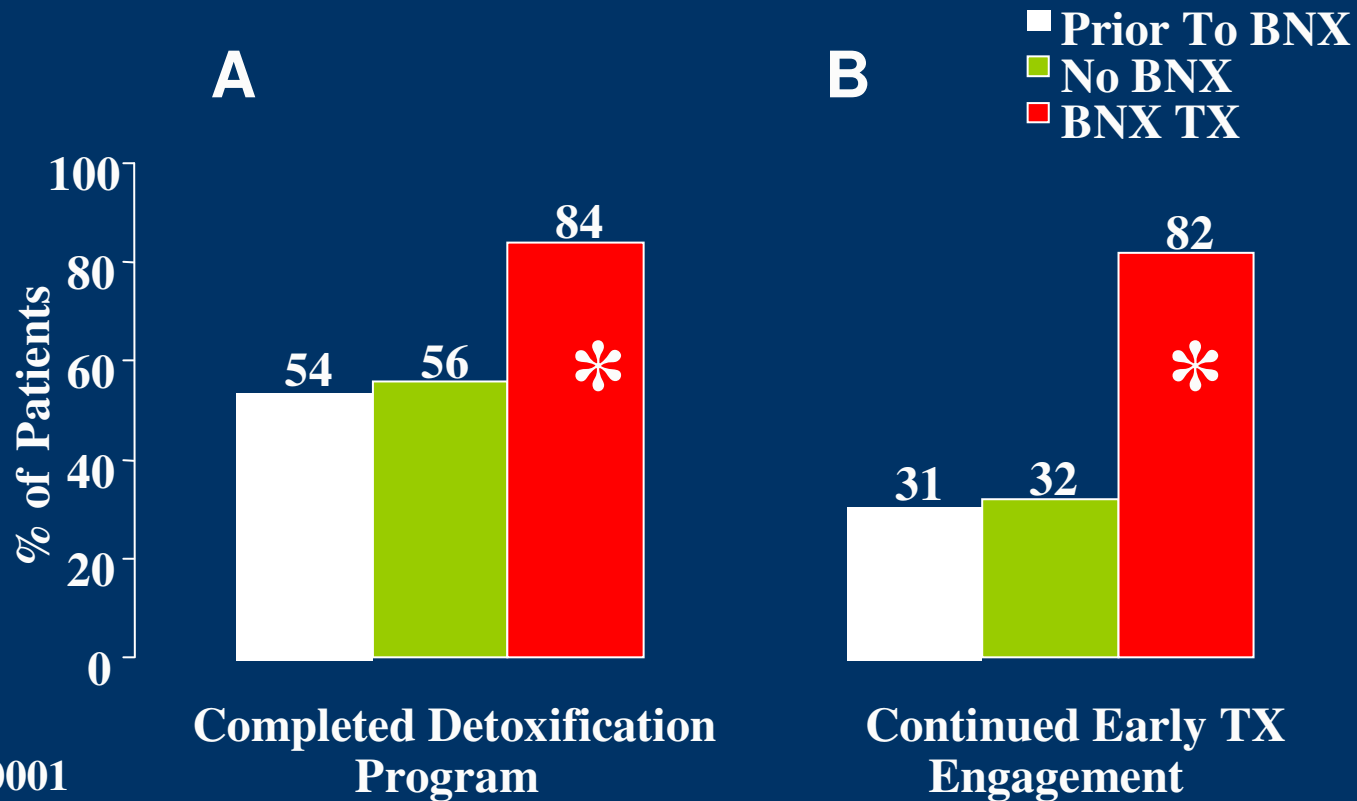
“We must find a better way to treat these patients, more that half of them are not continuing with treatment”

Maryhaven Medical Director

# Current BUP/NX Taper at Maryhaven

Day	BNX Dose (mg of bup)
0	Darvocet N 100, Clonidine 0.1mg po tid & Lorazepam 1 mg.
1	4 plus 4 more if not contraindicated (subutex for 1st dose if long-acting)
2	8
3	16
4	14
5	12
6	10
7	8
8-9	6
10-11	4
12-13	2

# Treatment Completion & Engagement



Percentage of patients, by treatment group, (A) completing detoxification and (B) engaging in treatment (i.e. accepting a referral and attending at least one day of treatment) beyond detox within a Maryhaven treatment program.

# Patient Level

## ◆ Barriers

- Early complaints of W/D with higher doses
- Medication diversion

## ◆ Incentives

“It’s a miracle, really!”

- Patients requesting BUP/NX at admission
- Less anxiety about detoxification

# Counselor Level

## ◆ Barrier

- “I’m not sure that this easy detox is such a good idea”  
Detox Counselor

## ◆ Incentive

- “The difference is unbelievable these patients now have a fair chance at treatment & recovery”  
Rehab nurse
- “It’s amazing you can sort them out by who is sick and who is ready to participate in treatment”  
Detox Counselor

# Administrative

## ◆ Barriers

- Concern about expense of medication
- Concerns about adopting an agonist medication

## ◆ Incentives

- Additional funding for BUP/NX adoption
- Positive exposure in the media
- Better patient retention
- More staff satisfaction
- Positive recognition by funding & certifying bodies