

Implementation of Evidence Based Practices: Challenges and Successes in Women's Treatment Programs

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Introduction & Background of Women's A&D Treatment Centers in Oregon

■ 1987-

- Women's Commission on Alcohol and Drug Abuse Issues was established

■ 1990-

- First request for Proposals for Women and Children's A&D Programs was published by the state of Oregon, grants were received across Oregon

■ Early 1990's-

- First Women's A&D Treatment Training was written & adopted by the State of Oregon
- Primary drugs of abuse by women were cocaine, heroin, amphetamines, marijuana & alcohol

■ Late 1990's-

- Oregon Health Plan was established with A&D and mental health benefits added the 2nd year resulting in a large influx of women/men of all ages entering treatment
- Use of ASAM criteria was adopted by the state & mandated for all providers

Introduction & Background of Women's A&D Treatment Centers in Oregon *Cont.*

■ 2000-

- More methamphetamine was being produced & use by women increased
- Big increases in mental health issues by women coming into treatment
- Two year decrease in the average grade level of women entering treatment from 11th grade to 9th grade
- Oregon Node of NIDA's clinical Trials Network established with 9 large providers
- Family Court models were established in Oregon

■ 2002-

- Loss of A&D / mental health coverage for approximately 100,000 people

■ 2003-

- Reinstatement of coverage but slow decline in the total number served from 120,000 to 19,000 over three years

■ 2005-

- law was passed that required EBP's

■ 2006-

- Women's Commission hired a consultant to write new women in treatment guidelines & present training at the Summer Institute

Senate Bill 267

This law is really a beginning step in bringing the standard of evidence based care to all of our mental health / alcohol & drug treatment programs.

- Oregon State legislature passed Senate Bill 267, requiring that increasing amounts of state funds be spent on Evidence-Based Practices (EBP).
- In 2005-7, 25% of state funds used to treat both mental health and A&D were to be EBP, in 2007-9, 50% and 2009-2011, 75%.
- A state stakeholder's workgroup devised guidelines for what EBP would be included; with a method of adding and extracting items and a list was produced.

<http://www.oregon.gov/AHS/mentalhealth/ebp/main.shtml>

How this project was done

Method

Brief interviews of 10 Women's A&D Programs including both urban and rural settings

Asked the following 8 questions:

- Name of program, description of services for women, women and children, adolescent girls. Capacity, # served in a year, if any differences in men's programs.
- EBP's used, any difficulties in implementing and solutions
- Training time, fidelity tools, updates in training
- Any outcome changes for clients?
- How did you choose the practice and why?
- Acceptance by staff and clients
- Would you do anything differently?
- What future research questions do you have?

The Results

We were reminded of many things
we already knew, and...

There were some definite
surprises

1. Services Summary

There were 3 rural programs and 6 urban programs

- All programs had residential services for adult women, 3 had residential services for adolescents.
- 9 had formal outpatient for both adults & adolescent, most offering child care.
- 1 program serves women only
- 4 programs serves women w/ children or are pregnant
- 5 programs serve women and women with children.
- 7 programs have a housing component

- 1 program is a primary mental health agency with addiction services, and 9 programs are primary A&D organizations offering mental health services to their clients.

Program Demographics

Adult Women Services

- 3 large programs serving 26-28 in residential setting
- 4 medium programs serving 10-15 in residential setting □
- 3 small programs serving 6-8 in residential setting
- Total capacity for women—155

Children services-< 5 yrs

- 1 large program serving 28 in residential setting
- 3 medium programs serving 13-15 in residential setting
- 5 small programs serving 5-8 in residential setting

Adolescent Girls

- 3 programs serving 4-8 in residential setting □
- Approximately 2000 women and adolescent girls are served in residential and outpatient settings at these 10 programs

2. Evidence Based Practices (EBP) used, any difficulties in implementing & solutions

- 9 using Seeking Safety
- 7 using Dialectical Behavioral Therapy (DBT) and one of those using it as primary
- 6 using Motivational Interviewing (MI) and one is using it as primary
- 5 using Cognitive Behavioral Therapy (CBT) with one using it as primary
- 3 using Matrix with one using it as primary □ 3 using 12 Step Facilitation
- 2 using Relapse Prevention
- 2 using Strength based case management
- 1 using Community Reinforcement Approach (CRA)
- 1 using Multi-Dimensional Family Therapy □ 1 using Motivational Enhanced Therapy (MET)

Evidence Based Practices (EBP) used, any difficulties in implementing & solutions *Cont.*

■ **Adult Outpatient**

- 4 programs that have selected a primary EBP are continuing them in Outpatient
- 3 are continuing seeking safety
- 1 is using DBT
- 1 is using Matrix

■ **Adolescent residential & Outpatient-2 reported using CBT and 1 using DBT**

■ **The number of Evidence Base Practices used at a site range from 1-6**

■ **Difficulties in Implementing**

All programs reported the need for more money to do the job right

3. Training time, fidelity tools, updates in training

■ Training

- All programs reported they needed more training
- 6 programs hired in house trainers
- Some programs hired trainers to come to the programs
- 1 program used state offered trainings only

■ Fidelity

- 2 programs use audio tapes, two other programs started using audio but stopped as cost became prohibitive
- 4 programs observe groups at least weekly
- 3 programs use group supervision
- 2 programs depend on Q.I. of client files

4. Any outcome changes for clients?

- All programs had anecdotal information only. 1 program is participating in an evaluation study and hopes to have outcome information at the end.
- Anecdotal comments
 - NIATx procedure resulted in increase return rate after first contact using Motivational Interviewing
 - More people completing / staying longer
 - 75% of women & children have been reunited
 - Length of stay has increased in residential from 4-5 months to 6 months

5. How did you choose the practice and why

- 3 programs used an organizational approach trying to match intervention with the client population through reading and discussion.
- The rest were a mix of several of the following:
 - Staff was already trained
 - Surveyed the clients
 - Attended a workshop and was impressed
 - Training was available and affordable
 - Talked to other providers
 - Talked with staff
 - Founded something that fit with current model
 - Met the trauma needs of clients

6. Acceptance by staff and clients

- Now there is overall acceptance by staff / clients
- It took at least 3 months of training & supervisory discussion groups for those starting a new intervention
- Some staff who were used to process groups had a harder time adjusting to manualized treatment
- Audio tapes were the hardest change
- Clients liked Matrix because of handouts, and look forward to Seeking Safety Groups
- Implementing / continuing EBP is harder in Outpatient because of higher turnover in staff. Residential staff has more identity with the service and work as a team
- Clear vision & structure has been very helpful

7. Would you do anything differently?

- 3 programs wished they had taken more time to plan, train and implement in the beginning as they had to stop implementation and start again after moving too quickly.
- Several programs reported that when they implemented a manualized group treatment, the demand for more individuals increased and had not been foreseen.
- **Other comments:**
 - Needed to identify clinical champions earlier-they may not be the managers
 - Needed to plan for training of residential support staff
 - Wish they were able to hire someone to monitor fidelity
 - Would like to be able to train entire staff in Seeking Safety
 - Would like to be able to know how to integrate the various interventions allowing for flexibility
 - Wish there was more field testing of the interventions to help make decisions
 - Wish there was more evaluation of the results
 - Wish that the organization had foreseen how much the additional training would enhance the employability of the staff. A plan should have been made to enhance the staff salary as they progressed

8. Future Research Questions

We will all benefit from understanding the answers to these questions. Providers specifically are eager to use this knowledge to bridge the disparity gap in treatment outcomes for women.

- How do the various interventions interact with each other?
- Which combinations of intervention work best for women?
- What interventions work for minority women?
- What does it cost to provide each of the interventions?
- Why is there more —drama on the women's unit compared to the men's unit?
- Why is there a higher turnover of women clients in treatment?
- What are the positive dynamics in residential care that supports recovery?
- Would like to compare CRA with other interventions
- What are good parenting models?
- Study a prevention model of treating anxiety and depression earlier to reduce later drug and alcohol abuse.
- Study early identification models to be used by community health providers.
- Study the generational impact of methamphetamine abuse
- Study and compare parenting models for effectiveness with A&D issues.

Some Conclusions of Interviewer

It is crucial to give staff / clients the information necessary to make the most effective choices

State Implementation of EBP mandates

- Provide necessary training about the options available
- Provide money for implementation training
- Provide money for ongoing training and fidelity monitoring
- Plan for special populations

Providers

- Plan for implementation time and on going training and fidelity monitoring costs
- Assess staff strengths and weaknesses, find champions
- Assess client strengths and weaknesses
- Allow time to train staff and answer questions
- Anticipate and plan for long time impact on staff

Your thoughtfulness and enthusiasm was invaluable.

**** If even one woman's life contains healthier choices because of this work you will have touched their life, and may have touched the lives of their children and their children's children.*

*As our Native American sisters say, you may influence lives for seven generations. ****

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