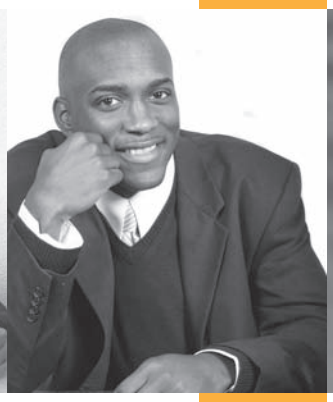
Central East
ATTC

Unifying science, education
and services to transform lives.

An Overview of Evidence-Based Practices:


Implementing Science-Based Interventions in Practical Settings

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

An Overview of Evidence-Based Practices: Implementing Science-Based Interventions in Practical Settings

Contents

This document was prepared by The Central East Addiction Technology Transfer Center (Central East) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The contents of this publication are solely the responsibility of the authors and do not necessarily reflect the official views of the U.S. Department of Health and Human Services (DHHS), SAMHSA or CSAT.

Updated and Revised Sept. 2009

Program Director
Thomas G. Durham, PhD

Editor
Aaron M. Williams, MA

Writers
Paula Jones
Susan Swanton, LCSW-C
Aaron M. Williams, MA

Central East ATTC
Unifying science, education and services to transform lives.

Overview

In 1998, the Institute of Medicine (IOM) issued a report entitled, "Bridging the Gap Between Practice and Research." This report discussed the gap between what scientific research found to be effective treatment for substance abuse disorders and what is actually practiced in substance-abuse treatment settings. The IOM report was the first of a number of reports that suggested that this gap existed. In a second report issued by the IOM in 2001, it was suggested that it took roughly 17 years for an effective research-based treatment intervention to become commonly used in substance abuse treatment practice. These reports began a movement spearheaded by the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA), to close the gap between research and practice. Federal agencies have begun to address this issue in a number of different ways including, the establishment of the Clinical Trials Networks by the National Institute on Drug Abuse, to enhance the delivery of scientifically-based treatments to drug abuse patients and the recent development of the NIDA/SAMHSA Blending Initiative designed to help increase the use of evidence-based practices in clinical settings.

The following document discusses dissemination and implementation of evidence-based practices in substance-abuse treatment settings. This document also includes a collection of updated works taken from the Central East Addiction Technology Transfer Center's (Central East) Dialogue newsletter related to evidence-based practices developed through the Blending Initiative. The articles describe how these evidence-based practices were implemented into practice at various treatment programs.

Evidence-Based Practices: What are They?

By Paula Jones and Aaron Williams

It is called the "cardiac assessment" and it can be applied to various types of interventions. Those carrying out the intervention "know in their heart" that it works. Certainly, there are many circumstances in which we can trust intuition. However, it is much better to have concrete evidence that something works than to simply believe that it does.

On the other end of the spectrum from the cardiac assessment are evidence-based practices. These are interventions for which there is consistent scientific evidence demonstrating that the desired outcomes are obtained. Rigorous assessments, such as multiple randomized clinical trials, consensus reviews of available science, or expert opinion based on clinical observation, are conducted to identify such practices. Practices that are subjected to less rigorous review are sometimes called promising practices or best practices.

The advantage for service providers in using evidence-based practices is that there is a very strong probability that the specified outcomes will be achieved. For providers working in a challenging field like substance abuse treatment, in which relapse is common for patients, the use of evidence-based practices can give them a decided edge as they work to help people overcome their addictions.

Not only can the use of evidence-based practices improve the final outcome, it can also improve the work environment and an agency's bottom line. Staff have clear guidance on how to carry out their duties and the expectationthat their efforts will show results. Funders have the assurance that resources are being directed toward something that will work, not something that might work.

Technology Transfer: Facilitating the Use of Evidence-Based Practices

In order to speed the use of any innovation into regular and routine practice, a process referred to as Technology Transfer is used. While the scientific community differs over the specific definition of technology transfer and the components of this process, simply put, it is defined as the multidimensional process that intentionally promotes the use of an innovation. Over the past year, the Addiction Technology Transfer Center (ATTC) network, funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT), has been reviewing the research literature in order to develop a common language and understanding of Technology Transfer and its core components. The ATTCs are a network of 14 regional centers and a national office that are charged with improving the addiction treatment field through the dissemination of evidence-based practices. After reviewing the research, the ATTC network came up with a more formal definition of Technology Transfer and its core components to help guide its work related to disseminating evidence-based practices.

Technology transfer – A multidimensional process that intentionally promotes the use of an innovation. Technology transfer begins during the development of an innovation, continues through its dissemination, and extends into its early implementation. This process requires multiple stakeholders and resources, and involves activities related to the translation and adoption of an innovation. Technology transfer is designed to accelerate the diffusion of an innovation.

Development – Creating and initially evaluating an innovation. An innovation can be an idea, technology, treatment or method.

CTN Nodes

The CTN is made up of 16 regional research centers, called nodes, distributed across the country. Each node is a partnership between research institutions and community treatment programs (CTPs). The nodes have areas of specialization such as targeting specific populations or investigating certain treatment modalities.

Appalachian Tri-State
California–Arizona
Delaware Valley
Florida
Long Island Regional
Mid-Atlantic
New England
New York
Northern New England
Ohio Valley
Oregon/Hawaii
Pacific Region
Southern Consortium
Southwest
Texas
Washington

Translation – Explaining the essential elements and relevance of an innovation, then packaging it to facilitate dissemination.

Dissemination – Promoting awareness of an innovation with the goal of facilitating adoption and implementation. Dissemination strategies include raising awareness, building knowledge, and distributing materials.

Adoption – The process of deciding whether to use an innovation. Adoption may or may not lead to implementation.

Implementation – Incorporating an innovation into routine practice. Implementation ideally includes a range of strategies designed to address individual, organizational, and systemic characteristics (e.g., skills training, administrative buy-in, and policy changes).

Diffusion – The planned or spontaneous spread of an innovation.

How are Evidence-Based Practices Developed and Identified?

The National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, supports over 85 percent of the world's research on the health aspects of drug abuse and addiction. NIDA's mission is to lead the nation in bringing the power of science to bear on drug abuse and addiction. NIDA works to ensure the rapid and effective transfer of scientific data to policy makers, drug abuse practitioners, other health care practitioners, and the general public. Part of this effort is NIDA's Clinical Trials Network (CTN).

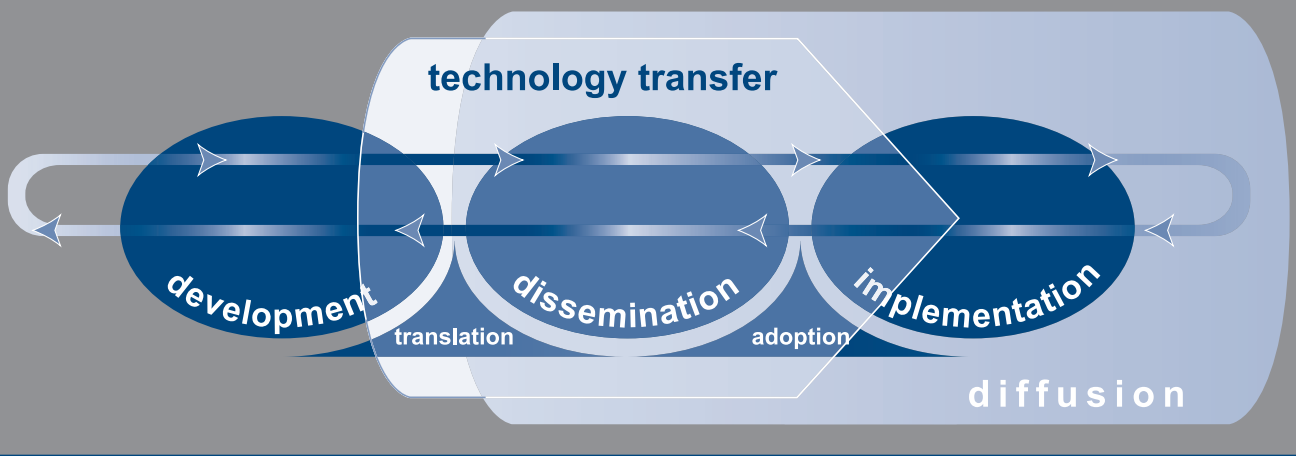
The mission of the CTN is to use science as a vehicle to improve the quality of drug abuse treatment across the country. The CTN provides a forum by which NIDA, treatment researchers, and community-based providers can cooperatively develop, validate, refine, and deliver new treatment options to patients receiving treatment

Diffusion of an Innovation

In order to illustrate our work, the ATTC Network has developed a cutting edge conceptual model of the diffusion of an innovation shown below.

First, during development, the innovation is designed and initially evaluated. Next, during translation, the essential elements and relevance of the innovation are explained and the innovation is packaged to facilitate its spread. In dissemination, awareness about the innovation is promoted with the goal of encouraging its adoption. Adoption is not a single decision, but a process of deciding to use the innovation. Finally, during implementation, the innovation is incorporated into routine practice in "real world" settings. Across the continuum, bidirectional communication is a critical component and is represented by a continuous feedback loop.

Highlighted within the conceptual model is technology transfer, a multidimensional process that intentionally promotes the use of an innovation. Technology transfer begins during development, continues through dissemination, and extends into early implementation. This process requires multiple stakeholders and resources, and involves activities related to translation and adoption. Technology transfer is designed to accelerate the diffusion of an innovation.



from community-based providers. This unique partnership aims to achieve the following objectives:

- Conducting studies of behavioral, pharmacological, and integrated behavioral and pharmacological treatment interventions of therapeutic effect in rigorous, multi-site clinical trials to determine effectiveness across a broad range of community-based treatment settings and diversified patient populations; and
- Ensuring the transfer of research results to physicians, clinicians, providers, and patients.

Why is the CTN necessary? Traditionally, the efficacy of new treatments for drug addiction have been demonstrated in specialized research settings, usually with limited patient populations. Such environments are often fairly removed from the "real world" and do not have to take into consideration the challenges facing real providers. For these new treatments and treatment approaches to fulfill their promise, advances achieved in research settings must be "transferred" to community-based settings where most treatment is provided.

Since the CTN was formed, 25 studies have been completed; three are currently underway. The studies have addressed a range of research topics including: use of Buprenorphine/Naloxone for opiate detoxification in both inpatient and outpatient settings; motivational interviewing; use of motivational incentives; brief strategic family therapy for adolescent drug abusers; reducing HIV/STD risk behaviors; HIV/HCV risk reduction interventions; and others.

With each of the studies, the research institutions pair with clinical treatment providers (CTPs). The CTPs provide the "real world" test for the intervention. Researchers and CTP staff work together to ensure that the intervention is applicable in the field. CTP staff receive training on how to implement the intervention and funding is often provided to support the additional activities required to conduct the intervention.

To help streamline this process of identifying evidence-based practices SAMHSA has developed the National Registry of Evidence-based Programs and Practices (NREPP).

NREPP is a system designed to support informed decision making and to disseminate timely and reliable information about evidence-based interventions that prevent and/or treat mental and substance use disorders.

The NREPP system allows users to access descriptive information about interventions as well as peer-reviewed ratings of outcome-specific evidence across several dimensions. NREPP provides information to a range of audiences, including service providers, policy makers, program planners, purchasers, consumers, and researchers. The NREPP website (www.nrepp.samhsa.gov) includes a search function that allows you to more easily scan through the programs and practices contained in the database.

Getting the Word Out: Dissemination of Evidence-Based Practices

What is the use of identifying evidence-based practices if there is no mechanism in place to get the word out to the field about their effectiveness? To effectively disseminate research findings, the CTN collaborates with the Substance Abuse and Mental Health Services Administration (SAMHSA) supported Addiction Technology Transfer Centers (ATTCs) through the NIDA/SAMHSA-ATTC Blending Initiative.

Developed in 2001, the Blending Initiative is designed to meld science and practice together to improve substance use disorder treatment and to move important scientific findings into mainstream addiction treatment practice. "Blending Teams," made up of staff from the ATTCs along with CTN researchers and CTP representatives, work together to develop a strategic plan and products to disseminate research results identified by NIDA. The ultimate goal is the adoption and implementation of evidence-based practices.

To date, five blending teams have been formed to disseminate important findings to the field. For example, when Buprenorphine was approved for the treatment of opioid addiction, a blending team was formed to educate the field about this new treatment option. The Buprenorphine Awareness Blending Team developed a training package to create awareness about Buprenorphine among multi-disciplinary addiction professionals. The materials include information designed to increase motivation for bringing Buprenorphine to local communities, as well as information about what to expect when someone is treated with this medication. Other blending teams include:

- Treatment Planning M.A.T.R.S., using the Addiction Severity Index (ASI) Blending Team;
- Motivational Interviewing Blending Team;
- Buprenorphine Detoxification Blending Team; and
- Promoting Awareness of Motivational Incentives Blending Team.

Challenges to Adoption and Implementation of Evidence-Based Practices

Even though they have been proven to be effective in bringing about the desired outcomes, evidence-based practices are not always easy for CTPs to implement. A significant barrier is resistance from CTPs and their staff. People do not like change and the implementation of new practices often requires change. Administrative processes must be modified and staff must be trained. Given the effort required, CTPs may have doubts about a specific practice. Will it work? Is it worth the effort to implement it?

The need for training is a significant barrier and staff "buy in" is essential to ensure the successful implementation of a new practice. Staff may see efforts to adopt new practices as a criticism of their performance, an indication that they were not doing a good enough job. Staff may also not agree with a specific practice, such as providing clients incentives to remain in treatment, and therefore be resistant to implementing these approaches. Appropriate training can help to address such misconceptions. Even with staff buy in, training requires time and resources, which are usually scarce commodities in CTPs. Ideally, training should be ongoing to ensure that staff maintain their skills and to accommodate staff turnover.

No matter whether staff are receptive or resistant, it is incumbent on management to ensure that the practice is implemented as intended by the researchers. To achieve the same outcomes as the researchers, CTPs must follow the same process in implementing the practice as was done in the clinical trial. This is called fidelity. If the practice is not properly implemented, it is unlikely that the desired outcomes will be achieved. Sometimes modifications to a practice are necessary, that's the real world, but these changes should be made consciously. Changes to the protocol should not be done by accident or due to lack of attention.

Finally, funders may not recognize the value of a specific evidence-based practice and may not be willing to support it. The question of funding is not a minor one. When they participate in the CTN process, CTPs are often provided additional support to carry out the required activities. This is rarely the case in the "real world." CTPs that implement best practices outside of a clinical trial must obtain the resources to carry out the new activities. Unsupportive funders can make this difficult.

Keys to Success

What elements are key to the successful implementation of evidence-based practices? One is to have a "champion" within the organization who supports the implementation of the practice and ensures that the practice is maintained once it is implemented. The issue of maintenance is significant. Once implemented, even with initial enthusiasm, new practices can gradually fall to the side as staff revert to their former practices. A champion can help to make sure that new practices are maintained.

How a new practice is introduced into an organization can make a big difference. Often, training is too limited, just one or two sessions. This has no staying power. A new practice must be "infused" into an organization. Training must be seen as an ongoing process, not a one-shot deal.

Finally, the effectiveness of the new practice must be evaluated. If the practice is implemented, following the researchers' protocol, there is a strong probability that the provider will see positive results. However, this is not an absolute guarantee. A thorough evaluation process will help the provider measure the outcomes. It will also help to identify areas where the practice has been incorrectly or not fully implemented, or areas where adjustments are needed. Evaluation can also help providers measure successful implementation, which can result in greater support for the practice by staff, funders, and most important of all, clients.

Resources

NIDA Clinical Trials Network
For more information on the CTN go to:
www.nida.nih.gov/CTN/index.htm

NIDA/SAMHSA Blending Initiative
For more information on the NIDA/SAMHSA Blending Initiative, include the training packages go to:
www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/index.asp

Short-Term Opioid Withdrawal Using Buprenorphine: An Example from the Field

By Paula Jones

When it was approved by the U.S. Food and Drug Administration (FDA) for treatment of opioid addiction in 2002, buprenorphine was seen as providing important new treatment options, treatment for opioid addiction could now be provided in medical settings, such as physicians' offices, rather than limited to methadone treatment facilities. By bringing opioid addition treatment into mainstream medical settings, buprenorphine has greatly expanded access to treatment.

In addition to use in maintenance treatment, buprenorphine is being used for medically monitored detoxification. With this treatment, medications such as buprenorphine help to suppress withdrawal symptoms during detoxification. It is important to note that by itself, medically assisted withdrawal does not constitute treatment it is only the first step in the treatment process. Without further treatment, relapse is likely.

Not all medically monitored detoxification programs are the same, especially in terms of the length of treatment. Programs can be as short as 5 days or considerably longer. However, there are important key elements to detoxification treatment. These include: evaluation/assessment; stabilization; and preparation for substance abuse treatment. The following profile provides one example of a medically managed detoxification program.

Buprenorphine Basics

- Buprenorphine is a long-acting partial mu opiate agonist that acts on the receptor targets of heroin and morphine but does not produce the same intense "high" or dangerous side effects.
- Buprenorphine's formulation with naloxone, an opioid antagonist (Suboxone), limits abuse by causing severe withdrawal symptoms in those who inject it. However, there are no adverse effects when it is taken orally (naloxone is minimally absorbed when taken orally).
- The FDA approved use of Subutex® (buprenorphine) and Suboxone® tablets (buprenorphine/naloxone) in October 2002. A large NIDA-sponsored, multi-site clinical trial demonstrated that buprenorphine significantly reduced opiate use and drug cravings in heroin users and confirmed its safety and acceptability.
- In 2000, Congress passed the Drug Addiction Treatment Act, allowing qualified physicians to prescribe narcotic medications (Schedules III to V) for the treatment of opioid addiction, which allowed access to heroin treatment in a medical setting other than methadone clinics.

Source: National Institute on Drug Abuse
www.nida.nih.gov/DrugPages/buprenorphine.html

Kent/Sussex Detoxification Center

The Kent/Sussex Detoxification Center is a clinically managed residential program serving clients addicted to heroin, cocaine, crack, marijuana, prescription drugs, and alcohol. The Center, a 20-bed facility located in Ellendale, Delaware, provides uninsured adult residents of the state access to detoxification from drugs and alcohol. About four years ago, the Center began offering medically monitored detoxification treatment using buprenorphine. Since then, the Center has provided detoxification treatment with buprenorphine to approximately 1,000 clients.

The Center takes a holistic approach to treatment, offering a wide range of services over the course of the 7-day treatment for opioid detoxification. These include:

- Medical assessment and individualized treatment plans for detoxification;
- Individualized assessment and referral/placement in treatment programs and individual sessions to prepare clients for treatment;
- Educational groups on the process of recovery, relapse prevention, self help, and medical issues;
- Special groups session on work opportunities, women's issues, and literacy;
- Alternative therapy such as acupuncture, reiki, and guided imagery;
- Daily open fellowship (12-step) meetings;
- Tuberculosis testing;
- HIV counseling and testing;
- STD counseling;
- Vaccination for Hepatitis B.

According to David Beling, MS, CADC, the Center's Substance Abuse Program Administrator, use of buprenorphine is critical to the success of this holistic approach. "Buprenorphine is a great asset to us since we offer all these additional services. The buprenorphine allows us to do the other things that we want to do with our clients and to set them up for the best possible aftercare. It allows clients to focus on their issues. It helps us get them to where they need to be."

Clients have been very receptive to the treatment. "They love it," reports Beling. "It works very well and there has been little to no mention of side effects."

A Change in Mind Set

Beling reports that integrating the use of buprenorphine was relatively easy, with no complaints from either staff or clients. The facilities medical director, Dr. Nathan Centers, plays an important role in the treatment and was a driving force in implementing the treatment protocol in the Center. "He believes in the use of the best available treatment practices," reports Beling. "Buprenorphine is a best practice."

There have been some critics of use of buprenorphine, both in general and for detoxification. "Some people think it is too easy, that it is a quick and easy fix," states Beling. "Yes, there are some people who might think that they can go ahead and take drugs and then just use buprenorphine to get off them. But making people suffer doesn't always give you the response you want or your clients need."

Detoxification: Basic Principles

1. Detoxification, in and of itself, does not constitute complete substance abuse treatment.
2. The detoxification process consists of three essential components, which should be available to all people seeking treatment:
   - Evaluation;
   - Stabilization;
   - Fostering patient readiness for and entry into substance abuse treatment.
3. Detoxification can take place in a wide variety of settings and at a number of levels of intensity within these settings. Placement should be appropriate to the patient's needs.
4. All persons requiring treatment for substance use disorders should receive treatment of the same quality and appropriate thoroughness and should be put into contact with substance abuse treatment ¬providers after detoxification.
5. Ultimately, insurance coverage for the full range of detoxification ¬services is cost-effective.
6. Patients seeking detoxification services have diverse cultural and ethnic backgrounds as well as unique health needs and life situations. Programs offering detoxification should be equipped to tailor treatment to their client populations.
7. A successful detoxification process can be measured, in part, by whether an individual who is substance dependent enters and remains in some form of substance abuse treatment/rehabilitation after detoxi¬fication.

Source: TIP 45. Detoxification and Substance Abuse Treatment
www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.85295

Response to Treatment

The use of buprenorphine has been successful at multiple levels. Initially, when the Center first started offering the treatment they were overwhelmed with people coming from outside the state seeking access to the treatment. Unfortunately, the Center can only serve Delaware residents, but it was clear the service was very much in demand. The Center averages about 12.5 clients a day in the program. The Center is currently exploring the possibility of providing services to clients with health insurance, which should keep it near capacity.

Beling estimates that about 90 percent of clients go on to other treatment programs, although not all of the clients continue on buprenorphine treatment. Dr. Centers is the medical director at two other facilities and is working to incorporate buprenorphine treatment at these sites. This will facilitate the transition of clients. While there is no formal evaluation component to the program, Dr. Centers is planning to survey clients after they leave the program (at 6 months and1 year) to assess the success of the treatment.

This article was first published in the Fall 2007 edition of the Dialogue.

NIDA/SAMHSA Blending Initiative Resources

The NIDA/SAMHSA Blending Initiative is designed to translate research into practice and to facilitate communication between stakeholders to make the best drug abuse and addiction treatments available to those who need them. Blending Teams are composed of NIDA researchers, community-based substance abuse treatment practitioners, and trainers from SAMHSA's Addiction Technology Transfer Center (ATTC) Network. The teams work to develop resources based on research conducted within NIDA's Clinical Trials Network (CTN) as well as other research supported by NIDA. Blending Team members design dissemination products to facilitate the adoption of science-based interventions. To date, two Blending Teams have developed products related to buprenorphine.

Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals

The Buprenorphine Treatment Blending Team developed a training package to disseminate information and enhance awareness among addiction professionals about buprenorphine treatment.

Products

- Training manual for 6-hour classroom modules
- PowerPoint presentation and CD
- Annotated bibliography
- Training Video
- Research articles

Short-Term Opioid Withdrawal Using Buprenorphine: Findings and Strategies from a NIDA Clinical Trials Network Study

This training package focuses on the administration of a 13-day buprenorphine taper for opioid-dependent patients. The training reviews results from research conducted by the CTN comparing buprenorphine versus clonidine in both inpatient and outpatient settings. The training provides instruction for implementing this protocol into treatment settings. Topics addressed include methods of evaluation and induction, the taper schedule, and use of ancillary medications during treatment.

Products

- 4-hour classroom training program addressing:
  - Rationale for providing detoxification to opioid-dependent patients;
  - Characterization of opiate withdrawal;
  - Goals of detoxification;
  - Results of the CTN studies;
  - Implementation training;
  - Patient and treatment staff perspectives;
  - Overdose risk following detoxification.
- PowerPoint slides and CD
- Brochure

To access these resources go to: www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/index.asp

Currently, as part of the NIDA Blending Initiative, the two buprenorphine training products are being updated to include information from a recently completed NIDA clinical trials study related to the use of buprenorphine in young adults. The updated products will be available in the winter of 2009.

Source: NIDA InfoFacts: Treatment Approaches for Drug Addiction
www.drugabuse.gov/Infofacts/treatmeth.html

Confirming the Effectiveness of an Evidence-Based Practice: Use of Motivational Interviewing in the Real World

By Paula Jones

"The study confirmed what clinical research had shown, that motivational interviewing is an empirically validated approach that is effective in clinical practice."

These are the words of Kathleen Carroll, PhD, of the Division of Substance Abuse of the Yale University School of Medicine's Department of Psychiatry. Dr. Carroll served as principal investigator on a clinical trial supported by the National Institute on Drug Abuse's Clinical Trial Network (CTN). The trial explored the effectiveness of integrating motivational interviewing (MI) techniques into the intake process of community-based substance abuse treatment providers. While there is ample evidence indicating that MI is an effective approach, little data were available on whether the approach could be integrated into standard clinical practice and whether it would result in improved patient outcomes. This is precisely the role of the CTN, to demonstrate that research-proven approaches, also known as evidence-based practices, can work in community settings.

Motivational interviewing is defined as a directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence about changing problem behaviors. The concept of MI was first described by William R. Miller, PhD, in 1983 and elaborated on by Miller and Stephen Rollnick, PhD, in 1991. Motivational interviewing is focused and goal directed, with its central purpose being the examination and resolution of ambivalence, which can be defined as simultaneous and contradictory attitudes or feelings, continual fluctuation, or uncertainty as to which approach to follow. Motivational interviewing is considered to be an approach to counseling, not a specific counseling technique.

The CTN brings together researchers and community-based clinicians to "bridge the gap" between research and practice. In the case of this clinical trial, the community-based providers were very enthusiastic about integrating MI techniques.

"The boat had already launched on this one. There were no significant barriers to implementation and MI was generally seen as very attractive by the clinicians. We just had to figure out how to structure the study in community-based sites," relates Carroll.

Five community-based treatment programs participated in the study. Three sites were in Oregon, one was in Virginia, and one was in New York. All the sites offer predominantly group-based treatment. This provided a challenge to the researchers since MI is more of an individualized approach. To address this, the MI intervention was integrated into the individual intake/assessment session that takes place before the patient is

Characteristics of Motivational Interviewing

- Motivation to change is elicited from the client, and not imposed for the outside.
- The client, not the counselor, must articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- Counseling should be done in a quiet and eliciting manner.
- The counselor should be directive in helping the client examine and resolve ambivalence.
- Readiness to change is not a permanent, ongoing state; it fluctuates based on interpersonal interaction.
- The therapeutic relationship should be viewed as a partnership.

Source: Rollnick, S. and Miller, W.R. What is motivational interviewing? *Behavioral and Cognitive Psychotherapy*, (23): 325-334, 1995.

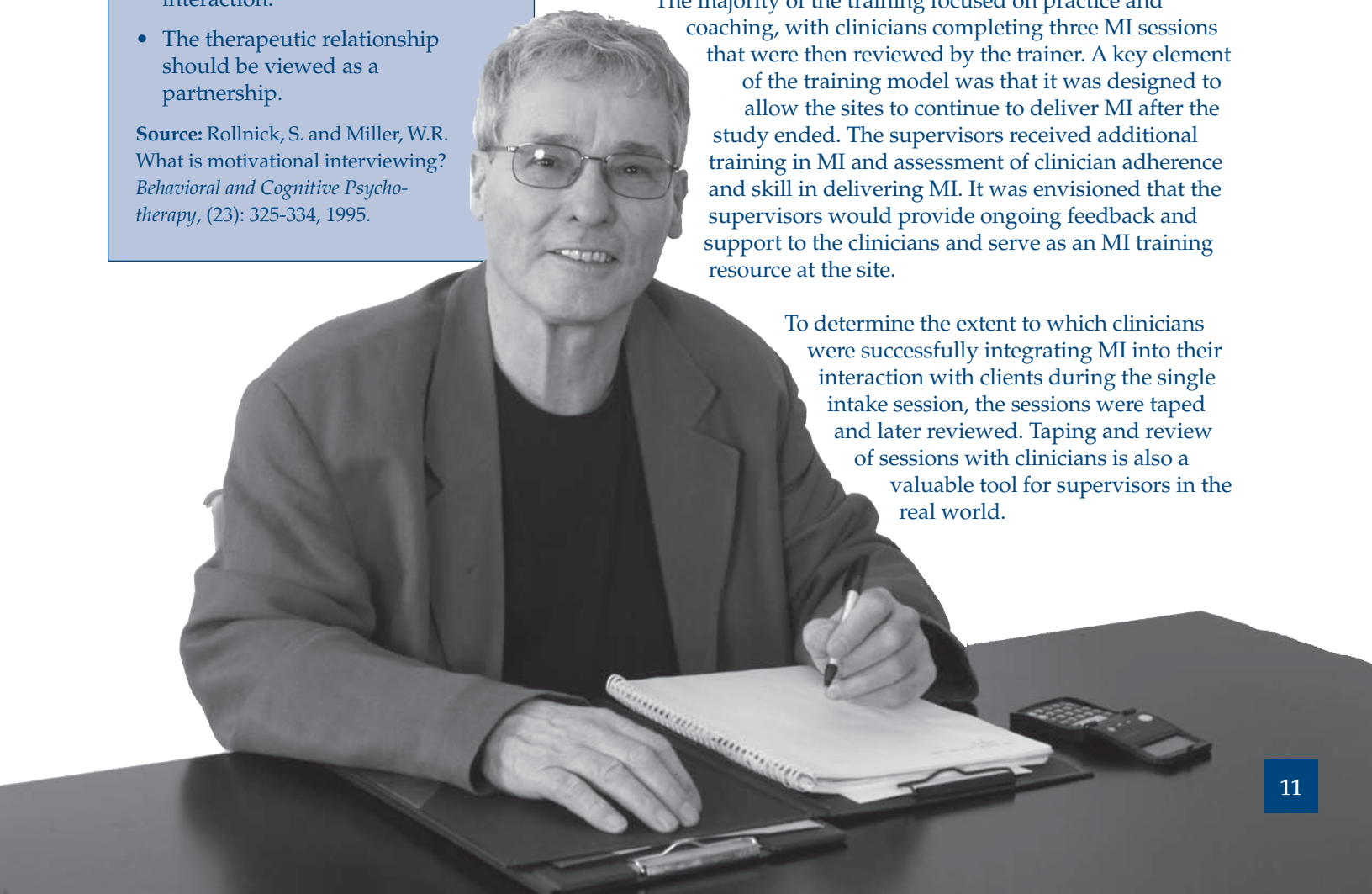
assigned to group treatment. The research focused on whether this relatively brief intervention would enhance retention and substance abuse outcomes.

A key aspect of the study was the training component for the clinicians. "It was important for us to think about what would work in community settings and how to best help clinicians deliver the services," relates Carroll.

A decentralized training model was adopted that was designed to provide consistent, high-quality training as well as ongoing supervision, the trainers would also supervise the clinicians and review tapes of the MI sessions to evaluate the clinicians adoption of the intervention. An MI expert trainer, with extensive experience in training and supervising clinicians in MI, was identified for each site. These experts attended an initial "training-of-trainers" seminar designed to standardize the training. The trainers then returned to the sites to train clinicians as well as the clinical supervisors at each site.

The training included review of MI principles and practices, use of training videotapes, lots of role playing to help in the development of skills, and discussion of how to implement the study protocol. The majority of the training focused on practice and coaching, with clinicians completing three MI sessions that were then reviewed by the trainer. A key element of the training model was that it was designed to allow the sites to continue to deliver MI after the study ended. The supervisors received additional training in MI and assessment of clinician adherence and skill in delivering MI. It was envisioned that the supervisors would provide ongoing feedback and support to the clinicians and serve as an MI training resource at the site.

To determine the extent to which clinicians were successfully integrating MI into their interaction with clients during the single intake session, the sessions were taped and later reviewed. Taping and review of sessions with clinicians is also a valuable tool for supervisors in the real world.



Trainable Clinician Behaviors

- Seek to understand the patient's frame of reference, especially through the use of reflective listening.
- Express acceptance and affirmation.
- Elicit and selectively reinforce the patient's self-motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change.
- Monitor the client's degree of readiness to change and ensure that resistance is not generated by going too fast for the patient.
- Affirm the client's freedom of choice and self-direction.

Source: Rollnick, S. and Miller, W.R. What is motivational interviewing? *Behavioral and Cognitive Psychotherapy*, (23): 325-334, 1995.

"To successfully implement MI, clinicians need training and support. This means real supervision, listening to clinicians as they use MI with real clients. Clinicians often think they are doing it, but if you listen to the tapes there isn't a lot of MI going on in the interaction with clients. Supervision and coaching is absolutely necessary," emphasizes Dr. Carroll.

The study did not explore whether ongoing supervision is necessary to ensure that clinicians continue to effectively use MI approaches. Dr. Carroll hopes to explore this question in the future. "Programs need to provide feedback, coaching and support. It is not enough to just to implement the intervention. People may change things or make some adaptations but the question remains whether there is enough MI taking place and whether it is done in a skillful way."

Dr. Carroll cites three important finding from the study. First, community-based clinicians can learn to implement MI effectively with training and supervision. Secondly, the training and supervision associated with the intervention enhanced the skills of the clinicians that received it. Clinicians that received the MI training were assessed by independent reviewers as more skillful overall, not just in the provision of MI, than their colleagues who did not receive training. Thirdly, MI significantly increased the rate of client retention, which is an important marker of treatment success. Motivational interviewing helped to keep patients engaged in the program.

The clinicians who participated in the study were volunteers. Thus, they tended to have an interest in MI and want to incorporate the approach into practice. The only issue of concern for most of the clinicians participating was how to employ the MI approach for patients who did not want to be in treatment. This issue was addressed in the training and through supervision. In general, the clinicians found that the approach could be applied to a wide range of individuals.

Dr. Carroll believes that many of the sites that participated in the study are continuing to use the MI approach. "It is hard to unlearn something like this," she relates. "The clinical supervisors are very interested in MI." She points out that for any community-based programs the training needs are ongoing, given staff turnover and the need for supervision to ensure that the approach is fully and correctly implemented.

The CTN has supported other studies that have explored MI. Dr. Carroll and her colleagues at Yale have studied the feasibility and impact of a three-session intervention in both English and Spanish. An additional study looks at the use of motivational approaches with pregnant women.

Integrating Research into Practice

The Motivational Interviewing Blending Team is working to develop and disseminate tools that will help community-based providers integrate MI into their practice. An array of materials for this package have been developed. The package, entitled Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA:STEP), includes both information on the results of the trial that can be used to educate policymakers and providers, on evidence-based MI practices, as well as tools to enhance counselor supervision.

The Blending Team focused on supervisors and the important role they play in working with counselors to ensure that they are fully and effectively implementing MI. Many of the materials developed are designed to build the skills of supervisors or are designed for supervisors to use in the training or evaluation of counselors. Materials include a tape rating guide for supervisors, an audio CD with four examples of standardized MI assessments (two in English and two in Spanish), and a self assessment of skills for counselors.

"The focus of the blending package is to assist supervisors in increasing the proficiency of MI-practicing clinicians," states Denise Hall, LPC, NCC of the Mid-Atlantic ATTC. "When an agency implements an evidence-based practice, supervisory knowledge as well as the ability to apply and transfer that knowledge is imperative for sustainability."

The tools are designed to help supervisors develop the skills necessary to rate the tapes of counseling sessions to determine the extent to which counselors are effectively using MI techniques. The rating system is the same as the one that was used in the CTN clinical trial. It was developed by Dr. Carroll and her colleagues at Yale and modified to make it more applicable for community providers.

The Blending Team released the materials for this package and they are currently available on the national ATTC website at: www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/miastep/index.asp. Because the materials are complex, the Blending Team is planning to use a train-the-trainer approach to support the dissemination of the package. Trainings will be held on a regional basis.

"The package is designed to be part of a comprehensive MI training initiative. MIA: STEP represents a continuum of learning through experience for both the supervisor and clinician," states Hall.

For More Information

Motivational Interviewing
www.motivationalinterviewing.org

NIDA/SAMHSA-ATTC Blending Initiative
www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/index.asp

This article was first published in the Fall 2006 edition of the Dialogue.

Integrating Evidence-Based Approaches: A Provider's Perspective

In order to obtain a better perspective of what it is like for providers to implement an evidence-based approach, we asked Ned Snead, manager of adult substance abuse services at the Chesterfield Department of Mental Health and Support Services his opinion on being apart of a CTN study.

What is the appeal of participating in a CTN clinical trial for providers and their staff? Participating in the MI clinical trial proved attractive to providers on several levels including the possibility of improved outcomes, enhanced staff skills, and an increased receptiveness on the part of staff to adopting additional evidence-based practices.

"Since the MI clinical trial, our retention rates have gone up and up. If clients engage, we are keeping them in treatment longer," relates Snead.

To benefit from the CTN process requires commitment from an organization and its staff. Management plays a significant role in both the implementation of the trial and in garnering staff support.

To integrate the research protocol, supervisors had to work closely with the researchers to make sure that the recruiting process was compatible with existing organizational processes. This required working with the research team for several hours each week to tweak the process in order to meet recruitment goals.

According to Snead, while staff was generally receptive to participating in the study and incorporating MI, there was some ambivalence about adding something new. "There was some fear about adding additional stresses to an already overloaded system. Staff had their own ambivalence about this change but were able to work through it with patience, support, and persistent encouragement," states Snead. "For the most part though, staff was very receptive."

Participation in the trial was voluntary for staff. Those participating agreed to the taping of client sessions and increased supervision. An indication of the level of staff interest in participating occurred when one of the counselors participating in the trial resigned. Several other staff members stepped forward to join the trial.

"We have a very inquisitive staff. They are extremely interested in improving their skills and their ability to serve clients," relates Snead. "Staff saw participation as an opportunity to get additional training at little or no cost to the organization."

The impact of the clinical trial has been ongoing within the organization. Participation in the initial CTN study increased staff's receptiveness to integrating evidence-based practices; it showed what could be done. Since the initial trial, supervisors and staff teams have incorporated other evidence-based practices. "Staff is empowered to identify and solve problems," states Snead. "Now, people step up with new ideas and concepts."

In addition, the use of MI has been expanded within the organization. All substance abuse staff have been trained in MI and there is ongoing supervision with two MINT (Motivational Interviewing Network of Trainers) clinical supervisors, Tom Mullins and Janet Loving. Plans are in place to video and audiotape client sessions in order to provide more feedback to staff on their effectiveness. Motivational interviewing techniques have also been integrated into some group sessions, using an evidence-based approach, the Motivational Groups for Community Substance Abuse Programs model, which was authored by Karen Ingersoll, Christopher Wagner, and Sandra Gharib of the Mid-Atlantic ATTC.

Following the MI clinical trial, Snead and his staff participated in a second CTN trial. They have found that incorporating one evidence-based approach is good, but incorporating a variety of evidence-based approaches is better. "If there is a good fit, we would gladly participate in additional trials," states Snead.

Snead stresses that not every evidence-based approach, including MI, is appropriate for each staff person and all situations. "MI is not used all the time and some counselors use it more effectively than others. Some don't use it at all, it is not in their skill set. You can't expect everyone to use MI. There needs to be a variety of approaches available for the diverse individuals we serve."

Motivational Incentives: Useful Tool in the Improvement of Treatment Outcomes

Providing Positive Reinforcement with Motivational Incentives

National Study Explores Impact on Abstinence and Attendance

By Paula Jones

Every parent is aware of the benefits of using rewards to influence their children's behavior, especially when it comes to encouraging them to do something that may be difficult. Parents know that positive reinforcement can work wonders. The same approach can be used to motivate drug users in outpatient substance abuse treatment to remain in treatment and abstain from drug use. The use of rewards, also referred to as incentives, in treatment is called contingency management (CM). CM interventions are based on behavioral research indicating that reinforcing a behavior can increase its frequency.

The efficacy of CM interventions has been demonstrated in patients dependent on opioids, marijuana, alcohol, and cocaine. Many of the studies of CM interventions have provided vouchers to patients, contingent on them attending treatment and/or abstaining from drugs. Despite the proven effectiveness of vouchers, some issues have hindered the adoption of this strategy in community-based programs. The primary issue is cost; in some studies participants could earn more than $1000 in vouchers. It is unlikely that many local programs could find the funds to support this level of reward.

Researchers at the Johns Hopkins University (JHU) School of Medicine conducted a clinical trial at eight community-based drug treatment sites across the country to explore the effectiveness of intermittent incentives. A chance to win a prize would be used to reinforce behavior instead of a guaranteed prize, the assumption being that a chance of winning was as good as a sure thing. The study is supported by the National Institute of Drug Abuse's (NIDA) National Drug Abuse Treatment Clinical Trials Network (CTN).

In the CTN study, patients earned a chance to draw chips from a container and win prizes of varying magnitudes. The difference between the voucher and the intermittent, prize-based studies is that with vouchers, patients receive a reward every time. In the prize-based study, 50 percent of the chips in the container stated "Good Job" and no prize was received by the participant. In the CTN study, an average of $400 in prizes could be won over 3 months if a participant submitted urine samples that tested negative for all target drugs (stimulants, opiates, and marijuana) as well as negative breath alcohol tests. This intermittent model is a much more affordable option for community-based providers.

While the study explored the impact of incentives awarded for drug negative urine samples under a particular set of procedures, Maxine L. Stitzer, PhD, principal investigator for the study, emphasizes that with incentives, the most important thing is the principle of positive reinforcement.

The researchers were fully aware of the challenges of sustaining an incentive program, particularly the financial challenges, and used a protocol that could make these programs more feasible for community clinics. Stitzer emphasizes that programs may not have the ability or the interest to implement the study protocol exactly as it was done in the CTN trial.

"Hopefully programs will adopt the principles of positive reinforcement and tailor the prize draw approach to their own clinical goals and patient needs," she states. "Positive reinforcement should be integrated throughout programs and the successes of clients should be celebrated. Bringing a positive spin to treatment can be great for the morale of both clients and staff."

Clinical Trials Network

The JHU study is part of the clinical trials process supported by the National Institute of Drug Abuse's National Drug Abuse Treatment Clinical Trials Network (CTN).

Participating in research can create challenges for the community treatment programs. Many have never participated in clinical trials before.

"Staff was open to the process but it was different from anything we had done. Research uses different language, requires different training, and has different expectations," relates Patricia Quinn Stabile, Program Director at HARBEL Prevention and Recovery Center in Baltimore, one of the sites in the JHU study. "We had to find common goals and provide training to staff."

To find out more about the CTN, go to: www.nida.nih.gov/CTN/index.html

Stitzer explains that many clients have received very little positive reinforcement in their lives and it can serve as a strong motivator. In addition, there is a prevailing attitude that clients should not be rewarded for what they should be doing anyway, which does not recognize the benefits that can be gained from reinforcing positive behavior.

The primary hypotheses of the CTN study were that participants receiving the incentives would remain in the study longer, submit more stimulant- and alcohol-free samples, provide a higher percentage of stimulant- and alcohol-free samples, and remain abstinent from these drugs for a longer period of time. The researchers also hypothesized that participants receiving incentives would attend more counseling sessions and submit a higher proportion of samples free of opioids and marijuana than participants receiving regular care.

The multi-site study provided a unique opportunity to evaluate the intervention within the context of the care provided at each site. Both the content and intensity of standard therapy were expected to vary across sites, as were usual care outcomes. By studying the intervention across several sites, the researchers could explore whether the intervention had an impact with different patient populations and care practices.

The Study

A total of 415 cocaine or methamphetamine users beginning outpatient substance abuse treatment were enrolled in the study between April 2001 and February 2003. Approximately half of the participants received standard care with the opportunity to receive prizes. The other participants received standard care. Standard care usually consisted of group counseling combined with some individual and family counseling.

To determine abstinence from drugs, participants were asked to provide two urine samples per week on non-consecutive days for at total of 24 samples over the course of the study. The first sample was taken at intake. Participants also provided a breath sample at each visit that was tested for alcohol use.

For participants in the incentive group, when their test results were negative for all the primary target drugs they drew one to 12 chips from the container. Chips were marked with one of four values: good job (50% of chips); small (41.8% of chips); large (8% of chips); and jumbo (0.2% of chips). Draws increased by one for each week

in which all the submitted samples were free of the primary target drugs. The number of draws returned to one if the participant had an unexcused absence or submitted a sample positive for a primary target drugs. To offset the lack of reinforcement early in the study when the number of draws was low, a single large prize was awarded after the first two consecutive weeks of abstinence. At each study visit, participants could also earn two bonus draws if their sample was free of opioids and marijuana. The maximum number of draws a participant could earn during the study was 204, which resulted in an average of approximately $400 in prizes.

Results

Participants receiving incentives while being treated in psychosocial counseling programs remained in treatment longer and attended more counseling sessions than those not receiving incentives. Those receiving incentives were also significantly more likely to achieve 4, 8, and 12 weeks of continuous abstinence. The incentive group had approximately twice as many participants with at least 4 weeks and at least 8 weeks of documented abstinence. The percentage of participants with 12 weeks of abstinences was nearly four times greater in the incentive group.

The study shows that retention, whether it was defined as the number of days between study intake and the last study visit, the proportion of participants who submitted samples each week, or the number of counseling sessions attended, was significantly lengthened when incentives were provided. Use of incentives also improved drug use outcomes. Little drug use was detected while patients remained in treatment. Thus, duration of sustained abstinence was lengthened during longer periods of treatment participation.

What is the Best Way to Use Incentives?

Since the researchers found many patients remained abstinent while participating in psychosocial counseling treatment, is it necessary to reinforce abstinence or should the reinforcement focus on attendance? The researchers suggest that incentives based on attendance may be a more beneficial approach. Focusing on attendance has additional benefits. For one, urinalysis frequency could be reduced, which would reduce the cost of administering the program. For the study, clinics were provided funds to hire a research assistant to conduct the urine testing, that is probably not a likelihood in the real world. In addition, the researchers suggest that attendance-based incentives might encourage patients who have relapsed to return to treatment rather than feeling they might be unwelcome because of their drug use. However, more research is needed to determine if this is the case.

Incentives

Good Job
No prize

Small
Toiletries, snacks, bus tokens, fast food gift certificates (approximately $1 in value)

Large
Kitchen objects, telephones, compact disc players, retail store gift certificates (approximately $20 in value)

Jumbo
Televisions, stereos, DVD players (approximately $80 to $100 in value)

"When individuals in treatment programs have already stopped using drugs, the main job of the provider is to keep them from relapsing," states Stitzer. "Incentives, by helping people stay in treatment longer, may also give them more of a chance to learn the skills they need to stay off drugs."

In the study, the sites that seemed to benefit most from the intervention were those with relatively low usual care retention rates (e.g., less than 7–8 weeks average retention). This indicates that the use of incentives may be most beneficial in clinics with low retention rates. However, since benefits were identified across all the sites, CM should be considered even when retention rates are relatively high.

The researchers had planned to explore the long-term impact of the CM intervention but were unable to follow up with a sufficient number of participants to draw any meaningful conclusions. Additional research is necessary to address the conditions under which CM can have a long-term impact in community-based settings.

Barriers to the Use of Incentives

Despite ample evidence that incentives can enhance treatment, there are still barriers to incorporating their use in community programs. As stated previously, cost is a major factor. However, as more emphasis is placed on evidence-based practices, funding agencies may be more inclined to provide resources for incentives. Clinics that operate under contracts where they are paid for units of service provided could increase their income by using incentives to motivate regular attendance at scheduled sessions. Some public sector funders are agreeing to support incentives when they are included by grantees as a line item in their budgets.

"Since the study we have done several small, limited projects that have used incentives," relates Quinn Stabile of HARBEL Prevention and Recovery Center. "We haven't been able to continue to use them as we did in the study but we are working to bring them back."

Getting the Word Out

The ATTC-NIDA Blending Team focusing on motivational incentives, headed by Lonnetta Albright, Director of the Great Lakes ATTC along with Anne-Helene Skinstad, Director of the Prairieland ATTC and Amy Shanahan of the Northeast ATTC, has designed an awareness campaign, Promoting Awareness of Motivational Incentives (PAMI) that educates policymakers, administrators, and clinicians about motivational incentives. The campaign uses a variety of vehicles, such as PowerPoint slide sets and videos. Information covered in the campaign includes: definitions; history of theory and use of motivational incentives; core principles; past and current research, and clinical applications. Included in the packet is a toolkit that contains: articles, an annotated bibliography, testimonials, sample letters to policymakers, FAQs, and other resources to help programs learn more about motivational incentives and promote the idea in their community. The campaign focuses on how to operationalize lower-cost incentive interventions, such as the intermittent reward approach used in Dr. Stitzer's study. To view or download this product go to: www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/pami/index.asp or the ATTC in your region for more information.

Another barrier is training. While the intervention may seem relatively easy to implement, staff need training on how to incorporate incentives into the overall program. Not only do attitudes need to be changed but new skills are also necessary. Ideally, training should be an ongoing process with regular feedback provided to staff.

Closely related to the training issue is the challenge of implementing a new process into the existing treatment protocol.

"It was more complicated to implement the use of incentives than we had anticipated," states Quinn Stabile of HARBEL. "We needed to track the use of incentives and make sure that they were provided in a fair way."

Perhaps the greatest remaining barrier is attitudes. From administrators to frontline staff, there needs to be an acceptance of rewarding clients' positive behavior.

"The take home message is the idea of celebrating success by applying positive reinforcement in the clinic," states Stitzer. "Each clinic can look at its own situation and decide what is important to it and their clients in terms of incentives."

While attitude is a barrier, it is not insurmountable.

"Some staff were resistant but others immediately understood the use of incentives. We emphasized in training that most businesses, as well as other models, reward people," states Quinn Stabile. "With training, staff understood the use of incentives."

First published in the Spring 2006 edition of the Dialogue

Implementation of Evidence-Based Practices

Implementation of evidence-based practices in treatment settings is a key component of the effort to improve services in the addiction treatment field. The following article describes an actual project undertaken by the Danya Institute designed to implement and sustain the use of evidence-based practices in Baltimore city.

Project BOOST: A Science to Service Model

By Susan Swanton, LCSW-C

Ensuring that new competencies learned in training translate to the workplace is at the heart of the "science to service" effort.

In January 2003, the Danya Institute began the implementation of Project BOOST (Baltimore-OSI Opportunities for Support through Training). This two-year project was funded by the Open Society Institute of Baltimore (OSI), and supported by the Baltimore Substance Abuse System, Inc. (BSAS), the funding and oversight agency for publicly funded substance abuse prevention and treatment services in Baltimore City. Project BOOST sought to improve the quality of care in the publicly funded substance abuse treatment system in Baltimore City through system-wide training and technical assistance to the 45 programs and 400 staff working in those programs.

Embracing principles of technology transfer, the project sought to enhance the competencies of staff at three levels of the organization: counselors, supervisors and program directors. Research has demonstrated that there are many factors that may facilitate or impede the application of new competencies learned by front line staff at training events. Some of these factors reside in the individual, some in the organization, and some in the larger treatment system. Given this, it is clear that effective and efficient transfer of skills, knowledge and attitudes acquired by front line staff take place in active partnership with supervisors and program directors. To affirm and nurture this partnership, Project BOOST was designed to provide training and support to counselors, supervisors and program directors.

This three-tiered approach was developed to foster the transfer of evidence-based practices by involving key staff positions at the beginning of the process. The staff members (program director, clinical supervisor, and counselors) greatly influence the adoption of "best practices" through their control over program policies, procedures and resources or through their direct responsibility for the implementation and maintenance of the new technology in daily practice. By involving them early in the process and educating them to the role they each play in technology transfer, it is hoped that resistance will be minimized and barriers to adoption can be identified early and addressed.

Counselor Support

Following guidelines suggested in the Addiction Technology Transfer Centers' publication, *The Change Book: A Blueprint for Technology Transfer* (Center for Substance Abuse Treatment, 2000), the project's initial intervention was to identify treatment competencies that would enhance the skills of clinical staff and improve treatment. A needs assessment was conducted and, based on the responses, three training topics were chosen to provide a foundation in basic counseling skills. Each of these topics ("Establishing the Therapeutic Alliance," "Group Counseling in Substance Abuse Treatment," and "Practice Management in Substance Abuse

Treatment" [this workshop was a combination of treatment planning, documentation and time management] was offered as a one-day workshop. Workshops were conducted by experienced trainers with reputations as experts in their fields, and used experiential and analytic learning formats to promote skill building among participants. Each workshop was offered a minimum of seven times each to allow all counselors to attend the workshop that would not seriously impact on the delivery of services at their program on any given day. These workshops were well received. The evaluations noted that 79 percent to 98 percent of the participants were either satisfied or very satisfied with the content of the training, the instructor, and the materials. After the training, 86 percent to 96 percent of the participants responded that they strongly agreed that attending the workshops enhanced their skills and knowledge. The counselors cited that the most common problems to transferring the newly learned technology into daily practice were time, staff resources, agency policies and procedures, client needs, and the need for additional training.

During the second year of the project, the design called for training all counselors and supervisors in an evidenced-based, manual driven approach. To select the manual, the Project BOOST Advisory Committee was convened. This committee consisted of research experts in the fields of substance abuse training and technology transfer, representatives from the State of Maryland's Office of Education and Training for Addiction Services (OETAS), a representative from Baltimore Substance Abuse Systems, Inc., and two representatives from the provider community. Available evidenced-based manuals were reviewed and two were identified for possible use in training. In order to ensure relevance, usefulness and program "buy-in," a meeting of program directors and clinical directors/supervisors was held to make the final selection. The workshop was conducted using a modified version of the "Best Practices in Addiction Treatment" workshop that was being piloted by the National Addiction Technology Transfer Center. This approach asks participants to review and discuss the manuals in terms of their ease of application, potential barriers to implementation, and efficacy to the target population. At the conclusion of the workshop, the participants selected Volume 2 of the Project Match Monograph Series, *Motivational Enhancement Therapy manual: A Clinical Research Guide for Therapist Treating Individuals with Alcohol Abuse and Dependence.*

The Change Book

Published in 2000 by the ATTC Network through a cooperative agreement with SAMHSA/CSAT, *The Change Book: A Blueprint for Technology Transfer* has become one of the most significant documents on the technology transfer and the initiation of change in substance abuse treatment and prevention settings. The Change Book is a tool to help organizations implement change initiatives that will improve prevention and treatment outcomes. The document is designed for administrators, staff, educators, and policy markers. The manual aims to increase the field's knowledge about effective technology transfer methods and build organizational infrastructure for implementing change.

The Change Book can be ordered or downloaded from the ATTC National office website at www.attcnetwork.org

Clinical Supervisor Support

The role of the clinical supervisor is a key factor in the successful transfer of any new technology to the workplace. Ideally, the counselor's day-to-day practice is monitored, evaluated and enhanced by the clinical supervisor and the clinical supervisor can reinforce newly acquired skills and practices. To that end, Project BOOST developed a program that concentrates on clinical supervision and the supervisor's role in supporting and sustaining technology transfer.

Initially, all supervisors were invited to attend a three-day workshop on clinical supervision sponsored by Project BOOST. Subsequent to this offering, OETAS agreed to offer their five-day, intermediate clinical supervision course at a very affordable rate. After the five-day course was completed, peer consultation groups began to meet. Participants were divided into groups by modalities. Seven groups were established, two for each modality of care (residential treatment, medication-assisted treatment, outpatient treatment), and one for adolescent treatment staff. Each group is held once a month for two hours. The frequency and

time frame was determined after input from participants who expressed both the desire for the groups and concern that attendance not put an undue burden on their already busy schedules.

Each month, a member presented a supervisee and discussed supervision issues and methods to improve their skills in supporting and developing their supervisee. On rare occasions, discussions were held on general clinical topics, but it is was felt that it is more useful to discuss issues as they are embodied in a staff person as this provides for concrete behavioral strategies and easy identification of the supervisor's success in implementing new skills.

The overall philosophy of supervision being used in facilitating these groups is a view of supervision as primarily a relationship of trust and support that promotes learning though discussion, reflection and development of self-awareness for the purposes of developing, empowering, and supporting competent clinical practice and ensuring quality patient services. Within this context, groups are structured so as to maximize the learning opportunity through the sharing of best practices and improving skills used in developing counseling competencies in counselors. The goals of the groups were: to improve clinical supervision skills; to explore supervision methods that promote technology transfer; to facilitate an exchange of expertise and best practices among participants; and, to establish a cohesive, working peer consultation group that will continue after the grant has ended.

These groups have been met with overwhelming support. Participants were grateful for the opportunity to exchange ideas with peers and to improve their clinical skills. The eventually developed a cohesiveness that allowed for meaningful self-disclosure and feedback to each other. This, in turn, increased their self-awareness, their knowledge of theory, their relationship skills, and ability to support, develop, and empower their supervisees.

Program Director Support

Quarterly meetings over lunch were held to provide a forum for directors to: provide feedback and guidance concerning the progress of the project and its usefulness to their programs; discuss issues in technology transfer; and participate in guided discussions about leadership and management topics of interest to them. To ensure relevance, directors were asked which areas of non-profit management they would like to improve. Responses fell into three broad categories: personnel issues (staff recruitment and development, dealing with "difficult employees"), management issues (grant writing, use of technology to improve performance, long-term planning vs. crisis management), and leadership issues (strategic planning, building collaborative relationships with internal and external customers, developing and

managing non-profit boards). In seeking guest lecturers for these luncheons, we moved outside of the traditional addiction treatment trainers or leaders, and sought resources from local universities and business. By doing this, we hoped to expose program directors to an expanded universe of technology from which they could draw to improve the quality of their performance and meet the many challenges programs currently face in meeting the needs of their customers and stakeholders.

Three meetings were held. The first was used to introduce Project BOOST to the directors. The second meeting addressed the problem of integrating a program's treatment philosophy into the daily practice of the staff through a discussion of the expectations of counselor competencies and performance evaluation. At the third meeting, the lecturer discussed operational tactics to achieve service priorities while juggling budgets and the concerns of funders, customers, boards, regulators and the community.

General Program Support

Technical Assistance: Another intervention used to ensure technology transfer is the provision of technical assistance to programs requesting assistance with specific issues in service provision. Meetings are conducted with the program and clinical director to develop an individual technical assistance plan that meets the needs of the program. Most of the technical assistance requested by the programs took the form of in-service trainings. The three most commonly requested topic areas are ethics, confidentiality, and treatment planning (problem lists, treatment plan, and documentation). Following these trainings, most programs requested additional assistance in improving the quality of their treatment plans and documentation. The second year of technical assistance focused on factors that are preventing or promoting the application of the "best practice" to daily clinical practice.

Summary

Through shoring up basic clinical and supervisory skills, and promoting the concepts of technology transfer and the role the counselor, supervisor and program director play in successful adoption of new technologies, the treatment system was primed to gain maximum benefit from the intensive training and supervision it will receive in an effort to implement a "best practice" in substance abuse treatment to improve the quality of care for the patients in Baltimore City.

Project BOOST has now ended. At the conclusion of Project BOOST, a comprehensive evaluation was done. This evaluation assessed the participants' general satisfaction with the training and materials they received during Project BOOST. In addition to general satisfaction measures, the evaluation also conducted a pre- and post training comparison of client retention rates at the programs involved in the training. This was done to ascertain the extent to which the trainings may have affected client retention. The results of the evaluation indicated that most of the participants were extremely satisfied with the trainings and materials. Two-thirds of the participants also indicated that they acquired new skills which should be useful in their work. In terms of client retention, most client retention rates remained steady across all treatment modalities (Methadone Maintenance, Intensive Outpatient, Residential, Detoxification, Outpatient), however client retention rates for Outpatient services increased significantly for 30, 45, and 90 days or more. While these results are promising indicators of the impact of this training program, more investigation is needed to determine if these increases in client retention are related directly to the training program or if there are other factors involved.

First published in the June 2004 edition of the Dialogue

References

Altfeld, D.A., (1999). *An experiential group model for psychotherapy*, 49 (2), 237-254.

Center for Substance Abuse Treatment (2000). *The Change Book: A Blueprint for Technology Transfer*. Produced under Grant No. 6 UDT11429-02-1. Rockville, Maryland.

Center for Substance Abuse Treatment. (2006). *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, Number 45. Publication No. (SMA) 06-4131. Rockville, MD: CSAT.

IOM (Institute of Medicine). 1998. *Bridging the Gap between Practice and Research*. Washington, DC: National Academy Press.

IOM (Institute of Medicine). 2001. *A New Health System for the 21st Century*. Washington, DC: National Academy Press.

IOM (Institute of Medicine). (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, DC: National Academy Press.

Iowa Consortium for Substance Abuse Research and Evaluation. (2003) *Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies*. Retrieved Sept. 9, 2009 from www.uiowa.edu/~iowapic/files/EBP%20Guide%20-%20 Revised%205-03.pdf.

Munson, C.E., (2002). *Handbook of Clinical Social Work Supervision*. New York: Haworth Social Work Practice Press.

National Institute on Alcohol Abuse and Alcoholism (1994). *Motivational Enhancement Therapy Manual: A Clinical Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence*. Project Match Monograph Series Vol. 2 NIH Publication N0.94-3723. Rockville, Maryland.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy,* (23): 325-334.

Smith, G. (2000). *Friendship within clinical supervision*. Retrieved June 5, 2003 from www.clinical-supervision.com.

Evidence-Based Practice Manuals and Web-Based Resources

National Implementation Research Network (NIRN)

The mission of the National Implementation Research Network (NIRN) is to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices.

http://nirn.fmhi.usf.edu/aboutus/01_whatisnirn.cfm

Clinical Trials Network Dissemination Library

The CTN Dissemination Library is a digital repository of resources created by and about NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN). It provides CTN members and the public with a single point of access to research findings and other materials that are approved for dissemination throughout the CTN and to the larger community of providers, researchers and policymakers.

http://ctndisseminationlibrary.org

The EBP Substance Abuse Database

The EBP Substance Abuse Database is one tool to help treatment providers make informed decisions about which science-based practices are most appropriate in which circumstances and for which individuals.

www.adai.washington.edu/ebp

National Registry of Evidence-based Practices and Programs (NREPP)

The National Registry of Evidence-based Programs and Practices (NREPP), formerly the National Registry of Effective Programs, is a system designed to support informed decision making and to disseminate timely and reliable information about interventions that prevent and/or treat mental and substance use disorders. The NREPP system allows users to access descriptive information about interventions as well as peer-reviewed ratings of outcome-specific evidence across several dimensions.

www.nrepp.samhsa.gov

Southern Coast Beacon: Evidence-based Practices

First article of a three-part series on evidence-based practices (Developed by the Southern Coast ATTC).

www.scattc.org/pdf_upload/Beacon001.pdf#search=%22evidence-based%20practices%20in%20addiction%22

Implementing Change in Substance Abuse Treatment Programs: Treatment Assistance Publication 31 (TAP 31)

Manual offers guidance on how to integrate evidence-based practices (EBPs) for substance abuse treatment into clinical practice. Informed by the realities of many substance abuse treatment providers, it suggests efficient solutions for implementing change based on proven methods.

http://download.ncadi.samhsa.gov/prevline/pdfs/SMA09-4377.pdf

Turning Knowledge into Practice

A manual for behavioral health administrators and practitioners about understanding and implementing evidence-based practices.

www.tacinc.org/Docs/HS/EBPmanual.pdf

Updated and Revised Sept. 2009
by the

Central East
ATTC
Unifying science, education
and services to transform lives.

Central East Addiction
Technology Transfer Center/
The Danya Institute, Inc.

8737 Colesville Road, Suite 300
Silver Spring, Maryland, 20910
p: 240/645-1145
f: 301/565-3390
www.ceattc.org

Director
Thomas G. Durham, PhD

Director of Operations and Conferences
Kathleen Hauck, CGMP

Administrative Assistant
Lilliam Matheson

Project Coordinator
Tamara Parris

Director of Training
Ryan Springer, MPH

Associate Director of Research and Information
Aaron Williams, MA

The Danya Institute, Inc, which manages the Central East ATTC, is a non-profit organization whose mission is to promote the professional development of health care professionals and to enhance service delivery systems nationwide through the transfer of empirically based research into practice.

The Danya Institute
www.danyainstitute.org