Barriers to implementation of evidence-based practices in community-based addiction treatment: Comparing staff reports of barriers from a nationwide sample.

Center for Addictions Research and Services,
Boston University School of Social Work

Alexander Cohen, M.S.W.
Lena M. Lundgren, Ph.D.
Maryann Amodeo, Ph.D., M.S.W.
Deborah Chassler, M.S.W.
Dylan Rose, B.A.

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Overview

National Study of Community-Based Programs' Implementation of Evidence-Based Practices for Substance Abuse Treatment

SAMPLE:

Identified **700** Community-Based Programs Funded by SAMSHA/CSAT from 2003-2008

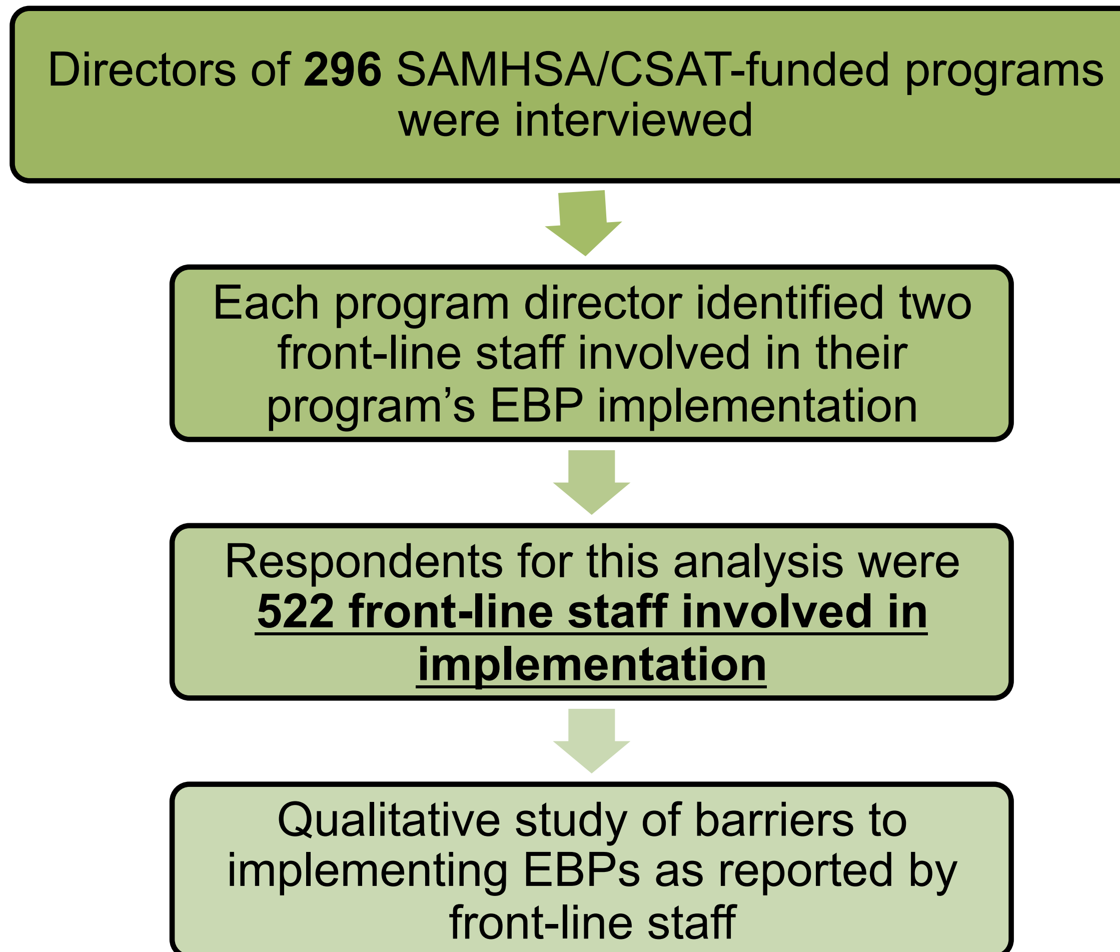
SELECTION:

Randomly selected **500** and collected information from SAMHSA Public Access Site

PROJECT GOAL:

Conduct phone interviews and web-based surveys with Director and two Staff in **330** Programs

Overview (Present Study)



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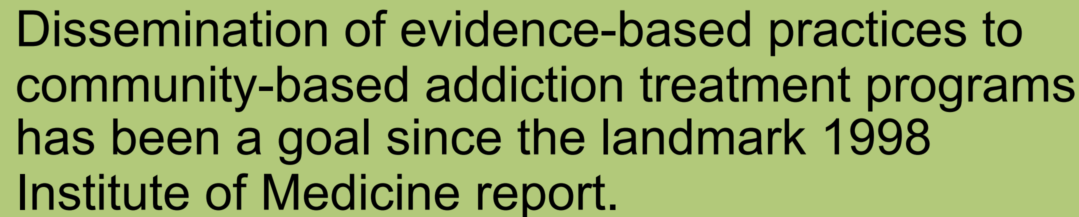
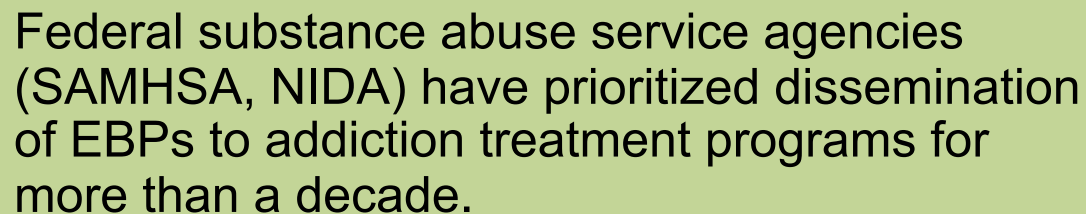
Context



Dissemination of evidence-based practices to community-based addiction treatment programs has been a goal since the landmark 1998 Institute of Medicine report.



Federal substance abuse service agencies (SAMHSA, NIDA) have prioritized dissemination of EBPs to addiction treatment programs for more than a decade.

For effective technology transfer, the addiction field has invested in learning about providers' attitudes toward and experiences with EBP implementation.

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Background

- Much research on staff and administrator ***attitudes*** about EBPs (Ball et al., 2002; Forman, Bovasso, & Woody, 2001; Fuller et al., 2007; Knudsen, Ducharme, Roman, & Link, 2005; McCarty et al., 2007; McGovern, Fox, Xie, & Drake, 2004; Willenbring et al., 2004).

- Some research on staff and administrator ***experiences*** in implementing EBPs (Bartholomew et al., 2007; Brown, 2004; Godley et al., 2001; Nelson & Steele, 2007; Thomas et al., 2003).

- Less research on ***barriers*** experienced during implementation process–Naltrexone (Mark et al., 2003; Thomas et al., 2003); Dual diagnosis---(Bartholomew et al., 2007).

- More focus on well-resourced, well-connected organizations, and less knowledge of community-based programs' experience (Willenbring et al., 2004).

Present study

- Interested in **perceived barriers** that front-line staff report having **experienced during EBP implementation**.
- Wanted to collect experiences of front line, community-based implementers—what they actually encounter when using EBPs.
- Interested in identifying the barriers most commonly encountered in community-based programs and for specific EBPs.
- Wondered if the impact or type of implementation barriers would vary across distinct EBPs.
- Wondered what EBP characteristics might explain any differences across EBPs in the perceived impact and type of barriers.

Research Questions

(1) What barriers do staff most frequently report?

(2) What patterns/categories best describe the barriers?

(3) What are the most common categories for the most frequently named EBPs?

Methods

- Participating programs received SAMHSA/CSAT awards (between 2003-2008) to implement services using specific EBPs.
- Sample was identified through publicly available SAMHSA/CSAT web-lists of funded projects.
- Programs were informed by us that this was a RWJ-funded study, totally unaffiliated with SAMHSA/CSAT.
- Program directors identified 2 staff involved in implementing EBPs—Staff were asked to report on 2 key EBPs implemented by their program.
- Participated in semi-structured, recorded telephone interviews on range of EBP issues, followed by confidential online survey.

Methods (continued)

- Q.(1): **“Describe barriers your project encountered in providing this treatment or service.”**

  Probes: “Could be external to the organization, internal to the organization, or related to the EBP itself”…“Things that got in the way when your project tried to provide the service”…“Challenges your organization faced in implementation.”

- Q.(2): “**What number best represents how much these barriers interfered with your project’s ability to provide this EBP?”**

  Scale from 1 to 10 (with 1= no interference and 10=total interference).

Analysis Steps

- More than 50 EBPs were named from 522 cases.
- Preliminary quantitative analysis showed 4 most frequently named EBPs (33.1% of all cases):
  - Motivational Interviewing (MI)
  - Adolescent-Community Reinforcement Approach (A-CRA)
  - Assertive Community Treatment (ACT)
  - Cognitive-Behavioral Therapy (CBT)
- These EBPs:
  - Are commonly used in the field—not unique to our respondents.
  - Represent a range of intervention approaches that could inform this issue of barriers to implementation.

Four Common EBPs

- **Motivational Interviewing (MI)**: Individual counseling; Designed to be compatible with brief treatment; Key skills-- listening reflectively, asking open questions, expressing empathy, affirming the client's change-related statements and efforts.
- **Adolescent Community Reinforcement Approach (A-CRA)**: 12-14 week outpatient program; Extensive certification and supervision; Parental/caregiver involvement is crucial; Therapists learn 17 A-CRA procedures.
- **Assertive Community Treatment (ACT)**: Designed for mentally ill. Coordinated team approach - social workers, rehabilitation specialists, nurses, psychiatrists. Case management; psychiatric services; employment/housing assistance (employment is expected); services 24 hours/365 days in home/locale.
- **Cognitive-behavioral Therapy (CBT)**: Individual/group counseling; to understand the intersection of thoughts, emotions and behaviors, and interrupt automatic responses to these patterns. Clients develop skills of problem-solving, affect-regulation, drug refusal, and anger-management.

Analysis Steps: For these 4 EBPs

- Included all "**barriers**" named by sample (barriers were participant answers to Research Question 1: "Describe barriers your project encountered in providing this treatment or service.")
- Developed a complete list of barriers; used Excel spreadsheets to organize and sort information by EBP.
- For unclear cases (9), two coders reviewed interview recordings for clarification, and agreed upon appropriate categorization.
- Two coders analyzed spreadsheets for themes—saw categories.
- Sought an inclusive set of **categories** to group barriers:
  - Adopted schema from Nelson, Steele, & Mize (2006) using 3 categories —"characteristics of: **(1) EBPs; (2) Practitioners and settings; (3) Clients**."
  - Added two categories to improve barring grouping: **(4) Resources; (5) Other**.
- Identified top 10 barriers for each EBP and sorted into categories.

Sample

Projects in 38 states and District of Columbia

Funded by many branches of SAMHSA

- Treatment for Homeless
- TCE/HIV
- Peer-to-peer Recovery Support Services
- Pregnant and Post-partum Women
- Assertive Adolescent Family Treatment

Respondents

- 71.4% female, 28.6% male
- 42.0 years old (mean)
- 51.7% have Masters degree or higher
- 50.7% have 5 or more years of experience in the field

Table 1: Twelve Most Common Barriers Reported by Front-Line Staff

1	**Client resistance/non-participation/disengagement**
2	**Staff shortage/high staff turnover**
3	**Staff resistance to/dislike of EBP**
4	**Training insufficient for program staff**
5	**Funding is insufficient or strictly allocated**
6	**Provider/organizational difficulty in adapting to an EBP**
7	**Transportation resources lacking**
8	**EBP model is too brief to adequately address client's needs**
9	**Staff training and attitudes are inconsistent or conflicting**
10	**Low access to affordable, subsidized housing**
10	**EBP is not flexible/adaptable**
10	**Clients are difficult to reach, follow-up, track**

**3 distinct barriers were each identified at the 10th highest frequency.*

Table 2: Ten Most Frequently Reported Barriers for Each EBP

Motivational Interviewing (MI)	Adolescent-Community Reinforcement Approach (A-CRA)	Assertive Community Treatment (ACT)	Cognitive-Behavioral Therapy (CBT)
• Not enough trainings on MI **(13)** • Staff resistance **(11)** • Staff struggle with adjusting to MI **(11)** • Client resistance and non-participation **(10)** • Staff training and attitudes are inconsistent/conflict **(8)** • MI philosophy conflicts with provider or organization **(7)** • MI takes more time than we have **(7)** • Staff shortage/high staff turnover **(5)** • Insufficient space for all services **(4)** • Working with mandated, criminal justice population **(4)**	• Certification process was burdensome/time consuming **(7)** • Model is not flexible or adaptable to client needs **(6)** • Staff shortage/high staff turnover **(5)** • Clients are difficult to reach, follow-up, track **(5)** • Client resistance and non-participation **(4)** • Providers resisted or disliked the model **(4)** • Not enough client referrals from community **(4)** • Parents of adolescents not helpful in clinical process **(4)** • Data management is time consuming **(2)** • Incomplete buy-in from organization **(2)**	• Not enough funding to implement fully **(9)** • Staff shortage/high staff turnover **(8)** • Limited affordable or subsidized housing **(5)** • Transportation **(5)** • Difficulty building relations and communicating with collaborators **(4)** • Community resources (including substance abuse treatment) are lacking **(4)** • Client resistance **(3)** • Homeless client population is very needy **(3)** • Coordinating with team as suggested is time-intensive **(2)** • Model requirements are too complex and demanding **(2)**	• Client resistance **(9)** • Client (individuals and family) attendance is poor **(3)** • Transportation **(3)** • Clients' cognitive barriers to understanding CBT concepts **(3)** • Clients with anti-social personality disorder **(2)** • Not enough time to complete treatment **(2)** • Low supply of well educated, qualified staff in geographic area **(2)** • Cultural/language barriers **(2)** • Client groups often resist prescribed content for a group session **(1)** • Staff did not receive enough training **(1)**

Table 3: Categories Proposed for Understanding Barriers to Implementing EBPs

Categories	Description of Category (examples)
EBP Characteristics	Requirements; content; delivery format; theory
Staff or Organizational Factors	Staff resistance; lack of experience; limited practitioner time; lack of training or supervision; lack of administrative support
Client Characteristics	Attendance; willingness; cognitive capacity; complex client presentation
Resources	Lack of referral sites for employment; housing; treatment; lack of transportation
Other	Difficulty with collaborating organizations; requirements from multiple funders; few needed services in community

Table 4: Most Prevalent Barrier Category for Each EBP

Barriers Related to:	MI (n=78 respondents)	A-CRA (n=39 respondents)	ACT (n=28 respondents)	CBT (n=27 respondents)
EBP Characteristics		38%		
Staff or Organizational Factors	54%			
Client Characteristics		33%		67%
Resources			82%	
Other				

Table 5: Most Common Barriers and Barrier Category

Barriers Related to:	MI (n=78 respondents)	A-CRA (n=39 respondents)	ACT (n=28 respondents)	CBT (n=27 respondents)
EBP Characteristics	• MI takes more time than we have	• Certification process was burdensome/time consuming • Model is not flexible or adaptable to client needs • Data management is time consuming	• Coordinating all ACT services is time-consuming • Model requirements are too complex and demanding	
Staff or Organizational Factors	• Staff resistance • Staff struggle with adjusting to MI • Variance in staff training and perspectives • MI philosophy conflicts with organization • Staff shortages/staff turnover • Not enough trainings on MI • Insufficient space for all services	• Staff shortages/staff turnover • Providers resisted or disliked the model • Incomplete buy-in from organization	• Staff shortages/staff turnover	• Cultural/language barriers • Not enough time to complete treatment • Staff not trained well enough
Client Characteristics	• Client resistance and non-participation • Working with mandated, criminal justice population	• Clients are difficult to reach, track, and follow-up • Client resistance and non-participation • Parents of adolescent clients not helpful in clinical process	• Client resistance • Homeless client population is very needy	• Client resistance • Client (individuals and family) attendance is poor • Clients' cognitive barriers to understanding CBT concepts • Clients with anti-social personality disorder • Client groups often resist prescribed content for a group session
Resources			• Not enough funding to implement fully • Limited affordable or subsidized housing • Transportation • Community resources (including substance abuse treatment) are lacking	• Transportation • Not enough well educated, qualified staff in our geographic area
Other		• Not enough client referrals from community	• Difficulty building relations and communicating with collaborators	

Table 6: Categorized Chart of the 12 Most Common Barriers Reported

Barriers Related to:	12 Most Common Barriers Reported by Staff Providers
Staff or Organizational Factors	(2) Staff shortage/turnover (3) Provider resistance to/dislike of EBP (4) Training insufficient (6) Provider/org. difficulty adapting to/understanding EBP (9) Provider training/perspectives/backgrounds differ
Resources	(5) Funding shortage/limited (7) Transportation lacking for clients (10) Low access to affordable, subsidized housing
Client Characteristics	(1) Client resistance/non-participation/disengagement (10) Clients difficult to reach/follow-up/track
EBP Characteristics	(8) EBP model too brief/treatment not long enough (10) EBP is not flexible/adaptable
Other	

Discussion

- Similar to prior research, findings suggest that barriers differed by EBP.
- Qualitative analysis also showed that type of barriers differed by EBP:
  - MI—**Staff or Organizational Factors;**
    - Themes= Philosophical differences; Staff training.
  - A-CRA—**Characteristics of EBPs *and* Clients;**
    - Themes= Certification requirements; Rigidity of model; Also client resistance/poor attendance.
  - ACT—**Resources;**
    - Themes= Organization/Grant program needed more money; Lack of community resources (housing, transportation).
  - CBT—**Client Characteristics;**
    - Themes= Resistance; Cognitive Capacity; Complex Presentation

Discussion

- For this sample of front-line staff from community programs, 'Staff or Organizational Factors' were most frequently identified as barriers to EBP implementation (taking 4 common EBPs together).
- 'EBP characteristics' were reported least often as barriers to service implementation.
- For the 2 individual counseling methods (MI & CBT), few barriers were named in the category of EBP characteristics (e.g., design, content, delivery method), indicating that staff may perceive less difficulty with using these treatment models compared to others.
- Except for A-CRA, each EBP had one barrier category that clearly predominated, and was different for each EBP.

Implications

- Implementation barriers need to be acknowledged explicitly and addressed by:
    - Designers of EBPs
    - Policy makers and funders who mandate EBPs
- EBP dissemination should include identification of possible barriers for each EBP, and explicit strategies to address such barriers.
- Community-based addiction programs should consider whether they have the organizational and community capacity to meet the demands of a particular EBP approach before implementing.
- Future research should examine actual barriers faced during implementation through direct tracking and observation.

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Limitations

- Only community-based, SAMHSA/CSAT-funded treatment programs.
    - Did not include treatment programs solely funded by states or by private insurance.
- Possible *staff* sample bias: Directors identified staff who implemented EBPs, and may have identified more educated and experienced staff
- May be variation among staff in level of involvement in EBP implementation—could influence perceptions of barriers.
- *Exploratory study*—this analysis cannot show causal connections between study variables.
- Possible *organizational* sample bias: organizations with less capacity to implement EBPs may never apply for, or are not awarded, federal grants; perspectives from those organizations are not included.