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Implementation of an evidence-based modified therapeutic community: Staff and resident perspectives

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ABSTRACT

The widespread successful implementation of evidence-based practices (EBPs) into community substance abuse settings require a thorough understanding of practitioner and client attitudes toward these approaches. This paper presents the first that we know of a qualitative study that explores staff and resident experience of the change process of a therapeutic community to an evidence-based modified therapeutic community for homeless individuals with co-occurring substance abuse and mental illness disorders. The sample consists of 20 participants; 10 staff and 10 residents. Interviews were conducted at the agency, recorded and transcribed verbatim. Transcripts were organized and coded from a grounded theory perspective. Themes and patterns of staff and resident experience were identified. The change in program structure from TC to MTC were perceived by staff as efforts to accommodate the particular needs of the homeless individuals with mental and substance abuse disorders and feeling they were inadequately prepared with inadequate resources to facilitate a successful transition. Participant descriptions were described in terms of loss of structure, loss of peers and being helped. Findings have potential to shape implementation of evidence-based practices in community substance abuse treatment.

1. Introduction

This evaluation is the first that we know of utilizing the narratives of staff and residents to explore their experience of the change process of a therapeutic community (TC) to an evidence-based modified therapeutic community (MTC) for homeless individuals with co-occurring substance abuse and mental illness disorders. The evaluation was initiated at the request of agency administration 1 year following the MTC implementation, in their effort to establish a subjective connection between the administration's program planning and operations used in the change process to guide effective stabilization of the MTC after realizing strategic planning for the change was problematic.

To support substance abuse programs in providing specialized services that focus on both treatment- and cost-effectiveness, the Substance Abuse and Mental Health Services Administration (SAMHSA) set out guidelines to adapt more promising practices and evidence-based treatments. One of these is the MTC for residential treatment of the homeless dually diagnosed population (SAMHSA, 2003). While the supply of evidence-based treatment continues to grow, the substance abuse field lacks comparable evidence about how to implement those treatments in real-world care.

This evaluation addresses the challenge of implementing an evidenced-based MTC from staff and residents perspectives, as research suggests that innovations are more likely to be widely and successfully adopted when the perspectives of potential users are captured and incorporated at the development stage (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004).

1.1. TC evaluation studies

There is a vast body of outcome literature supporting the success of the TC model with chronic substance abusers (Condelli & Hubbard, 1994; Carrroll & McGinley, 1998; De Leon, Sacks, Staines, & McKendrick, 2000; Jainchill, 1994). Nuttbrock, Rahav, Rivera, Ng-Mak, and Struening (1997) demonstrated that clients assigned to a TC exhibit greater reductions in substance use and psychopathology than those assigned to other community-based treatments. Research supports the notion that the strongest predictor of TC program completion is the existence of social supports and meaningful relationships that are at the center of the "community as treatment" (Alfs & McClellan, 1992; Lam & Rosenheck, 1999).

TCs have traditionally provided abstinence-based services for drug users. However, there is a need for a more modified treatment with a harm reduction approach for a particularly vulnerable subset of persons; the homeless mentally ill substance abuser with mental

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illness. Between one-fourth and one-third of homeless persons have a serious mental illness such as schizophrenia, bipolar disorder, or major depressive disorder and substance abuse (Burt & Cohen, 1989). These "triple disorder" individuals are a particularly vulnerable subgroup with complex service requirements resulting from low levels of educational achievement, limited job skills, lack family and social supports, experiences of violence and victimization, and frequent contact with the criminal justice system. Identified barriers for homeless individuals to enter and complete treatment include: lack of transportation, lack of support services, lack documentation, scheduling difficulties, daily contact requirements and ineffective treatment methods (Fischer & Breakey, 1991).

1.2. MTC outcome evaluations

Evaluations of the MTC utilizing quantitative methods have demonstrated positive outcomes for substance use and employment, housing (De Leon et al., 2000), mental health (Rahav et al., 1995a, 1995b), HIV risk, higher client treatment retention, and significantly lower rates of illegal drug use, crime, and psychological dysfunction (Sacks, Banks, McKendrick, & Sacks, 2008), higher levels of improvement on all measures of psychopathology, and retention of the most impaired individuals (De Leon, Sacks, Staines, & McKendrick, 1999).

Effective dual diagnosis programs combine mental health and substance abuse interventions that are tailored for the complex needs of clients with comorbid disorders. Drake, Goldman et al. (2001) describe the critical components of effective programs, which include a comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interventions; provision of help to clients in acquiring skills and supports to manage both illnesses and to pursue functional goals; and cultural sensitivity and competence. Integrated substance abuse and mental health treatments have been found to reduce alcohol and drug use, homelessness, and the severity of mental health symptoms (Drake, Yovetick, Bebout, Harris, & McHugo, 1997; Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998).

1.3. Implementation research

Organizations are constantly under pressure to change. The needs of clients and demands for services change with social conditions, availability and accessibility of services, and individual client histories. Implementation research looks at how new practices get implemented following the decision to adopt (Klein & Knight, 2005) however there is a paucity of evidence about implementation. Current approaches to implementing dual diagnosis programs involve organizational and financing changes at the policy level, clarity of program mission with structural changes to support dual diagnosis services, training and supervision for clinicians, and dissemination of accurate information to consumers and families to support understanding, demand, and advocacy (Drake, Goldman et al., 2001).

The concept of evidence-based practice (EBP) has gained increasing attention during the past 15 years. Despite both increased awareness of what evidence-based practice is and on its value in human services, few approaches with proven efficacy have actually transferred into the clinical, or real-world setting. A number of factors have surfaced as barriers to transfer of efficacious practice. The research indicates that the organizational context in which a practice is delivered has a significant impact on the fidelity of the treatment, and on its success or failure. Organizational context refers to factors that differ from the research environment, including a host of confounding variables (motivation, skills, caseloads, supervision and support); readiness to change, and the organizational culture (Luongo, 2007).

Fixsen et al. (2005) maintain that an implementation model without a clear plan for change will not work. Based on a review of the literature, the authors suggest that successful implementation is possible only through simultaneous interventions at practitioner, organization, system-of-care, Federal, State, county, and local levels. Fixsen et al. point out that implementation is not an event but a mission-oriented process involving multiple decisions, actions, and corrections.

1.4. Practitioner perspectives on implementation

Research highlights barriers associated with practitioner attitudes toward evidence-based practices (Baydar, Reid, & Webster-Stratton, 2003; Essock et al., 2003), front line providers (Aarons & Palinkas, 2007; Aarons, 2004; Hysong, Best, & Pugh, 2007), clinicians' lack of skills and knowledge, lack of cohesive service learning and limited training time (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001), insufficient time, resource constraints, and inadequate access to guideline materials (Davies, Spears, & Pugh, 2004).

Proctor et al. (2007) captured the perspectives of agency directors on the challenge of implementing evidence-based practices. Agency directors indicated limited access to research, provider resistance, and training costs as implementation challenges. In addition, Proctor reports that agency leaders seemed to think about their workforce in a manner consistent with a staged view of provider development, students were welcome sources of information about EBP, while long-time providers often succumbed to ruts' that made them resistant to new practices.

Notably, there is a paucity of implementation of evidence-based practice in substance abuse treatment from the client, consumer or service user perspective.

2. Methods

2.1. Evaluation design

Qualitative methods have become central to program evaluation in either stand-alone studies or mixed-methods designs (Padgett, 2008). A qualitative evaluation design was employed utilizing semi-structured interviews of staff and residents across wide variations in program processes (Royce, Thyer, & Padget, 2009). The agency Institutional Review Board approved all study protocols. The study period was from September 2007 to May 2008.

2.2. Prior to the change from TC to MTC

An agency hosting residential TC sites, received SAMSHA grant funding to improve short- and long-term outcomes for homeless clients with substance abuse and mental illness disorders through modifications and specifications to one of their traditional TC sites. In preparation for the implementation of the MTC, administration informed management staff of the grant's purpose, revised admission criteria, and treatment modifications. Management informed staff individually and in staff meetings.

Training occurred prior to implementation to ensure staff competency by an expert in MTC administration and treatment. The training included multiple presentations of the theoretical foundations of the MTC program, specific contents of the MTC model of treatment and plan for implementation. In addition, dual disorder terminology, prevalence rates, symptoms of psychosis, and special issues for this population were discussed.

However, during the implementation process a number of staff changes occurred, including resignations, transfers, and new hires. TC residents not meeting the MTC new diagnostic criteria were