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Use of evidence-based substance use treatment practices in Mississippi

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ABSTRACT

Over the past decade, substance abuse treatment professionals have begun to implement evidence-based practices (EBPs) into the treatment of substance use disorders. There is a growing body of research on the diffusion of EBP in addiction treatment; however, less is known about individual state initiatives to implement EBPs among community providers. The current study aimed to evaluate the progress of an initiative of the Mississippi Department of Mental Health (MDMH) to increase the implementation of evidence-based substance abuse treatment practices by certified providers. In addition, the study examines potential barriers to implementing these practices. To accomplish this goal, we reported the findings of two surveys of Mississippi addiction professionals conducted in 2010 and in 2013.

1. Introduction

The number of deaths from drug overdose in the US has grown significantly in recent years (Levi, Segal, & Miller, 2013). While overdose mortality rates have increased for both urban and rural communities, individuals living in rural communities are around twice as likely to overdose on prescription drugs than individuals living in urban areas. This is particularly relevant for predominantly rural states such as Mississippi, which saw its rate of deaths from drug overdose triple over the 14-year period between 1999 and 2013 (Levi et al., 2013). Because of this growing problem, it is of paramount important that efficacious methods for substance abuse treatments be disseminated and implemented in community settings. This is of particular importance in rural areas where fewer resources are available and there is a greater likelihood of mortality due to overdose.

Since the emergence of the evidence-based medicine movement in the early 1990s, there has been a push for behavioral health professionals to utilize evidence-based practices (EBPs) with the hopes of providing more effective, empirically supported, and standardized interventions to individuals seeking treatment (Prendergast, 2011). Although there is a growing body of research on the diffusion of EBPs in substance abuse treatment (see Garner, 2009 for a review), little is known about individual state initiatives to promote evidence-based substance abuse treatment practices, this knowledge would enable inferences to be made about the implementation of EBPs in rural areas. An assessment of 49 state substance abuse agencies found that almost every state reported activities aimed at facilitating the adoption of EBPs (Rieckmann, Kovas, Fussell, & Stettler, 2009). Financial incentives, regulations and accreditation, and education and training are among the strategies being utilized by states to promote EBPs. However, the study did not report the strategies employed by individual states, the specific EBPs being promoted, or the effectiveness of their efforts. This information is vital if we are to understand how EBPs are being implemented in rural areas. The purpose of this paper is to describe Mississippi's efforts to facilitate the adoption of EBPs among publically funded substance abuse treatment providers and to report changes in providers' attitudes toward and use of EBPs over time.

1.1. Implementation of evidence-based practices in substance abuse treatment

The federal government has devoted significant resources toward the development of evidence-based treatments for

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substance use disorders and the transfer of research findings on what works to clinical practice (Brown & Flynn, 2002). The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA) disseminate information on and promote the use of evidence-based substance abuse prevention and treatment practices through the National Registry of Evidence-based Programs and Practices (NREPP), the Clinical Trials Network, and other initiatives. The "gap" between the use of treatment practices that have been shown to be effective in the empirical literature and what is being practiced by clinicians (Arthur & Blitz, 2000) appears to be narrowing at least for some EBPs and under certain conditions.

A review of the research published between 1998 and 2008 generally found more positive attitudes and support for psychosocial EBPs than pharmacological EBPs (Garner, 2009). National surveys of attitudes toward buprenorphine, which was approved by the FDA in 2002 for the treatment of opiate dependence, have changed from 81% of physicians being uncomfortable prescribing buprenorphine (West et al., 2004) and 86% of counselors not being aware of the effectiveness of buprenorphine to more positive attitudes toward and greater knowledge about the effectiveness of pharmacological EBPs following trainings and involvement in research networks (Knudsen, Ducharme, & Roman, 2007; McCarty, Rieckmann, Green, Gallon, & Knudsen, 2004). Moreover, naltrexone (approved for the treatment of alcohol dependence in 1994) and buprenorphine adoption rates have increased over time (Fuller, Rieckmann, McCarty, Smith, & Levine, 2005; Knudsen, Ducharme, Roman, & Link, 2005).

Research also suggests greater support for specific EBPs depending on the context. Private treatment centers were significantly more likely to adopt pharmacological EBPs than public treatment centers (Knudsen, Ducharme, & Roman, 2006; Knudsen et al., 2007). A study of public addiction treatment programs in New Hampshire (McGovern, Fox, Xie, & Drake, 2004) found that clinicians were currently using the 12-step model the most and were more willing to adopt 12-step facilitation, relapse prevention therapy, cognitive-behavioral therapy (CBT), and motivational interviewing than contingency management, behavioral couples therapy or pharmacotherapies. Research in other states also shows that motivational interviewing and CBT are the most commonly used EBPs, but knowledge about and use of a number of other EBPs for the treatment of substance use disorders varied considerably (Haug, Shopshire, Tajima, Gruber, & Guydish, 2008; Herbeck, Hser, & Teruya, 2008; McBride, Voss, Mertz, Villanueva, & Smith, 2007). These studies indicate differential community readiness to adopt certain evidence-based practices. Further study of treatment providers' attitudes and experiences with a variety of EBPs are needed.

1.2. Attitudes

Historically, community clinicians have held negative views toward empirically supported treatments as these treatments emphasize between-group differences, rather than individual differences (Henderson, MacKay, & Peterson-Badali, 2006). More specifically, research examining the efficacy of EBPs traditionally focuses on group-level treatment outcomes in a controlled setting, rather than an individual's treatment outcome in the "real world," and reportedly fails to account for problems that arise in clinical practice, such as a lack of adequate resources. As such, many clinicians who provide treatment for substance use disorders have preferred to rely on the methods in which they were trained while in graduate school or have come to prefer through their own experience (Miller, Zweben, & Johnson, 2005). Given that clinician attitudes can influence utilization of EBPs, it is critically important to understand the factors that influence these attitudes in order to improve dissemination efforts.

A number of variables have been shown to influence clinician attitudes toward EBPs. For example, certain clinician characteristics, such as level of education and existing knowledge of EBPs, have been found to influence attitudes. Specifically, clinicians with doctoral degrees and who have prior experience with EBPs hold more positive attitudes than clinicians who have a lack of knowledge and experience (Nakamura, Higa-McMillan, Okamura, & Shimabukuro, 2011). This makes sense, as doctoral level clinicians may have received exposure to and training on EBPs during their graduate training. On the other hand, drug treatment counselors with lower levels of education or who obtained their college degree many years ago may not have been exposed to EBPs during their academic training. Furthermore, many publically funded treatment programs hire recovering individuals with lengthy sobriety as counselors and these providers may be less open to new treatment practices. As such, it is important to understand community providers' attitudes toward EBPs, as well as how these attitudes influence adoption and implementation (Aarons, 2004).

1.3. Training

Given that research has indicated that education level and knowledge of EBP influences attitudes (Nakamura et al., 2011), there is reason to assume that providing training on an EBP could improve clinician attitudes. In fact, training has been found to increase positive attitudes toward EBPs, particularly for those with bachelor's degrees (Bearman, Wadkins, Bailin, & Doctoroff, 2015). However, many treatment provider organizations do not provide sufficient training to clinicians in the correct methods of delivering evidence-based practices with fidelity. For example, Olmstead, Abraham, Martino, and Roman (2012) conducted face-to-face interviews with directors of substance abuse treatment centers, during which the use of several evidence based treatment models were discussed, including: Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Contingency Management (CM), and Brief Strategic Family Therapy (BSFT). The results of the interviews indicated that, of those centers that employed these strategies, a large percentage (34–72%) did not provide formal training on the practice for their clinicians. This is particularly problematic as attendance at one training workshop or the use of treatment manuals without adequate training is often ineffective in enabling clinicians to become proficient in the skills necessary for successful implementation of evidence-based treatments (Miller, Sorensen, Selzer, & Brigham, 2006). Furthermore, providing adequate training on a number of the "branded" EBPs is not feasible. There are just too many evidence-based interventions for the existing system of substance abuse treatment to adopt, let alone implement the practice with fidelity (Carroll & Rounsaville, 2006).

1.4. Implementation status of evidence-based practices in MS

In 2008, the Mississippi Department of Mental Health (MDMH) developed its first strategic plan to better serve the mental health needs of the state by providing guidance for community-based mental health services throughout Mississippi. Since its inception, the plan has been updated multiple times with the most recent update occurring in 2013. One of the major goals of this strategic plan is the implementation of evidence-based practices, such as trauma-focused cognitive-behavioral therapy (TFCBT), by the 15 publicly funded community mental health centers (CMHC) and by other treatment providers in Mississippi that are certified by MDMH. In addition, the plan aimed to increase the use of