

Connecticut Partnership Targets Substance-Abusing Parents

In 1999 a coalition of practitioners, researchers, and State and community treatment program administrators in Connecticut jointly developed, implemented, and conducted a successful research study of the use of motivational enhancement treatment (MET) techniques in a community treatment program. From its initial stages through its conclusion, the pilot study exemplified how researchers, treatment providers, and administrators can work together as equal partners to meet their own and each other's needs and goals—and benefit the families of substance-abusing caregivers.

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By all accounts, overcoming the practical obstacles to conducting research in a working community clinic required a spirit of cooperation, mutual respect, ongoing communication, sensitivity to each other's needs, a willingness and ability to adjust to those needs, and considerable extra work on the part of all participants. Yet, participants expressed a high level of excitement and enthusiasm about being part of the project, felt they benefited personally and professionally and expressed desire and willingness to participate in similar joint efforts.

Today, some 2 years after completion of the study, the benefits of the collaboration continue to bear fruit in the training programs and clinical practices of the participating organizations and other agencies. In addition, the success of the study warranted its replication on a wider scale in NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN), a nationwide network of regional research centers linked to community treatment programs.

The Problem

In 1997, the Connecticut Department of Children and Families (DCF) reported increasing child abuse associated with sub-

stance abuse by a primary caregiver. "Some 70 percent of families in our protection service caseload have substance abuse as either a contributing factor or the cause of abuse and neglect," says DCF's Joseph Sheehan. DCF therefore established Project SAFE (Substance Abuse Family Education), under which child welfare workers connect the primary caregivers of children in these families with community substance abuse treatment programs for assessment and free treatment, if needed.

Since Project SAFE was initiated, about 68 percent of more than 24,000 referred caregivers have completed an initial evaluation of their substance abuse problem. However, prior to the research study only about one-third of those who were recommended for substance abuse treatment returned to the clinic to start treatment.

The Response

Two years ago, DCF, Advanced Behavioral Health (ABH)—a network of Connecticut substance abuse community treatment providers, Genesis Center—a provider in the ABH network, and treatment researchers from Yale University Medical School in New Haven embarked on a joint study to

MET and Standard Interview

MET techniques seek to increase the substance abuser's motivation to change his or her behavior. Clinicians conducting evaluation interviews would, for example, raise the participants' awareness of the personal consequences of substance abuse, express empathy, and avoid confrontation and resistance. By contrast, in the standard evaluation, the clinicians collected information about why the participant was referred, his or her history of substance abuse and psychosocial problems, and a urine specimen for analysis. Both interviews took about 90 minutes.

determine whether Genesis counselors could increase the number of Project SAFE parents who started treatment by using research-tested MET techniques in the evaluation interview.

"I think ABH had been looking for opportunities to build this kind of research-practice collaboration for some time," says Dr. Kathleen Carroll of Yale University School of Medicine, who led the study. "The opportunity came when ABH and DCF shared with us their concerns about how Project SAFE got people with substance abuse problems to substance abuse clinics for initial evaluation, but few seemed to engage in treatment. Our research question became, 'Can we find simple strategies to engage this challenging population in treatment?'"

"After a series of meetings, we decided we could move forward with a collaborative study," says Debbie Beckwith, executive director of ABH at that time. "We at ABH and our providers were very excited about participating in the project, especially if it would help to engage clients who wouldn't show for treatment. That was the main impetus. Of course, becoming involved in research is prestigious in itself."

"When Dr. Carroll and ABH approached us about doing the project, we were very interested," says Nancy Hyland, director of substance abuse services at Genesis Center. "We wanted to see how

effective motivational interviewing would be with the Project SAFE population."

"Plenty of data suggested that motivational interviewing was effective with smoking and alcohol-using populations, but few data existed on motivational interviewing for mixed groups of drug users likes this," Dr. Carroll says. "Some are admitting to substance use, some are not; they could be coming in for alcohol, heroin, cocaine, marijuana, or benzodiazepine abuse. So the treatment had to be flexible. The key techniques associated with motivational interviewing—rolling with resistance, avoiding argumentation and allowing people to hold onto their ambivalence—fit this population incredibly well. It seemed natural to try motivational interviewing to engage Project SAFE clients."

The Results

Between March and June 1999, DCF case-workers referred 60 clients, most of them women, for substance abuse evaluation at Genesis Center. Clients who agreed to participate in the study were randomly assigned to either the standard evaluation or a MET-enhanced evaluation. The entire process—explaining the study, obtaining the client's consent, random assignment, and delivery of either intervention—was completed within a single 2-hour period.

The study's results showed that 59 percent of participants who received the enhanced intervention and were referred

for treatment returned for at least one additional session at Genesis. By comparison, only 29 percent of those who received the standard evaluation came back. (For a full description of the study, its methodology, and results, see Carroll, K.M.; Libby, B.; Sheehan, J.; and Hyland, N., 2001. Motivational interviewing to enhance treatment initiation in substance abusers: An effectiveness study. *American Journal on the Addictions* 10:335-339.)

"The outcome data were significantly favorable," DCF's Mr. Sheehan says. "The 'show rate' for the initial visit for treatment was doubled. As treatment sessions progressed, the rate of attendance did decrease. In most instances, the clinician who evaluated the patient was not the same one who treated the patient, and that presumably was one reason why attendance decreased. One conclusion is that everybody [involved with the client] has to be on board and exposed to the training."

"The project really was a pleasure," concludes Dr. Carroll. "There weren't many problems that came up. When we began to develop the motivational interviewing protocol for CTN, this experience helped us to be very attuned to the perspective of clinicians. We could anticipate certain problems and prevent them. It was a huge payoff for us that way."

"This was our first venture doing a research project with a university," says Ms. Hyland of Genesis. "It was an exciting experience for us and we benefited from the knowledge gained from collaboration between the two facilities. I would tell anyone out there who is considering doing this: Go for it!"

The Experience of Science-Practice Collaboration: In Their Own Words

Laying the Groundwork

Joseph Sheehan: DCF, ABH, and Yale very quickly arrived at a consensus to do the MET study. We wanted a community provider with seasoned clinicians and exten-

sive experience with Project SAFE's population, and that was part of the ABH network.

Bryce Libby: Genesis Center seemed like a good choice because they had always been responsive to changes in the Project SAFE contract. We took the idea to them, and they were excited. There was some caution as well, partly because they weren't sure what to expect. One reservation was that research was new to them. They had a concern about what would be required of their staff and what resources would be made available to them. As with most providers, they tend to be understaffed, their fiscal resources are usually 'maxed out,' and the staff is under a lot of pressure. They really wanted to hear Yale say the right things: 'We will compensate your staff; we will also involve you in the whole process.' Yale came through.

Debbie Beckwith: We wanted to make sure that Genesis Center understood their role and that Yale could answer any questions that they had. Initially, there were ethical concerns about the control and treatment groups. We made it clear that the control group would get the usual treatment and the study group would get an add-on to try this new therapy. It was a very productive, open discussion.

One important concern was that we not overburden the providers with data collection. We decided together to use the client survey and clinical summary that Genesis was already using on the DCF contract, with only two questions added to the client survey.

Dr. Carroll and I also felt it was important that Genesis be compensated for extra staffing or administrative expenses related to the study. This was important because providers typically are not reimbursed when they are doing research projects. So, in addition to free training provided to their clinical staff, the agency was reimbursed for some of its expenses.

The Collaborators



Joseph Sheehan

- The **State of Connecticut Department of Children and Families** (DCF); initiated and supports Project SAFE (Substance Abuse Family Education). **Joseph Sheehan** was manager for Project SAFE at the time of the study.

- **Advanced Behavioral Health** (ABH), a statewide network of almost 50 community-based providers of substance abuse and mental health services in Connecticut; secures and manages contracts to provide treatment services for populations served by agencies

such as DCF and the Department of Mental Health and Addiction Services. Providers in the ABH network furnish substance abuse services to Project SAFE clients. **Debbie Beckwith**, executive director of ABH at the time of the study, is now an independent consultant. **Bryce Libby**, ABH's manager for Project SAFE, is currently project director for the New England Node of NIDA's CTN.



Nancy Hyland

- **Genesis Center**, a community treatment program located in Manchester, Connecticut; provides evaluation and treatment services for Project SAFE clients.

Genesis is part of the ABH network and had never been involved in research before this study. **Nancy Hyland**, director of substance abuse services at Genesis Center, oversees the outpatient substance abuse program at Genesis and coordinates and monitors the Project SAFE contract with DCF. **Sue Caulkins**, addictions clinician at Genesis, provided treatment services to Project SAFE clients

referred for evaluation at the time of the study; she now provides addiction services for the Connecticut Department of Correction.



Dr. Kathleen Carroll

- **Yale University School of Medicine** in New Haven, Connecticut; led the research study on motivational interviewing with Project SAFE clients as part of the NIDA-supported Psychotherapy Development Center for Opioid and Cocaine Use. **Dr. Kathleen Carroll** is professor of psychiatry, Division of Substance Abuse at Yale University School of Medicine. She was principal investigator for the motivational interviewing study with Project SAFE clients at Genesis and is now principal investigator for the New England Node of the CTN.

Nancy Hyland: Members of my staff who were selected to participate in this project met with Yale University and ABH, who basically introduced the concept. Certain staff would use MET and other staff would approach clients in our standard manner. The motivational interviewing staff was selected, and Yale sent someone to train the staff here at Genesis.

Sue Caulkins: Nancy Hyland approached me and said she would like me to pick up part of the study. I was excited because the study gave us an opportunity to receive more training that might be helpful with the Project SAFE population. That was a tough population: Often people were angry about coming in for the evaluations, and for the most part they were very resistant to treatment.

The researchers came in several times to talk with us, work out details and let us know what the training would be, what was expected of us. They were professional, supportive, and encouraging—wonderful to work with. My impression was that most people were pretty excited to be part of this study. I think that most of us felt it would be of benefit, not only to increase our skills, but also to really engage our clients a bit differently. Also, there were some monies involved, and in a community agency, any little extra money coming in is wonderful.

Kathleen Carroll: We worked with the clinicians to come up with a training and supervision schedule that would work with their time constraints. Instead of a typical 3-day training protocol such as we'd use in a formal psychotherapy clinical trial, we made it a 1-day training protocol with a lot of consultation, as needed. Instead of using an existing manual, we fit some of the key motivational interviewing techniques into an existing set of clinical procedures. So this wasn't exactly pure motivational interviewing: It was more an

Research Time Versus Clinical Time

The big challenge [in conducting the study] was the difference in the time frames that researchers and practitioners live within. Researchers had to learn and come to appreciate that when you are in an outpatient provider setting, you are always in crisis mode. When you have a question, you need an answer. Sometimes even 24 hours is too long to have to wait for a response. Researchers think in a different time frame, in light of the complexity and attention to detail required for good research. Dealing with the difference can be a big problem in some situations, but if people are responsive, the issue can be manageable.

– BRYCE LIBBY, ABH

integration of MET techniques into what was a very standardized first interview.

We also encouraged clinicians to call the training supervisor when they had a specific question. If they got into trouble, they could get some help. Also, it was extremely helpful to have the ABH network and administrators involved at every step, as they provided critical liaison between us and Genesis, not only administratively and helping with data collection, but their knowledge of the realities of the clinical programs helped us to be sensitive to the issues involved.

Issues in Implementation

Sheehan: Supervisors of the clinical staff were in on all the planning meetings from the beginning. For those who actually saw the clients, the most extensive involvement before we began the study was the all-day training session, where the model was presented, role-plays took place, and feedback was given to the clinicians. Everybody in the room was receptive to learning new interventions or at least reframing what we had been doing clinically. There was enthusiasm. I didn't pick up any hesitation or anxiety in terms of trying something a little different.

Beckwith: In addition to planning and preparing up front so that everybody understands the project, another critically important piece is ongoing communication to keep everyone aware of what's going on. Every week, there were face-to-face meetings between Yale, ABH, DCF, and Genesis. The provider, Genesis, was also free to call Bryce [Libby], as well as Yale, with questions at any time.

Hyland: Because the approach was randomized, we had to have at least two staff persons free at the time of any single appointment. That made it a little more challenging for our program, but my staff had high energy and enthusiasm; they were okay with the extra requirement.

We set up a protocol for randomizing clients, and we set up a staffing pattern that would have both a MET staff person and what we called a 'standard' staff person freed up at the same time when a referral was coming in. Two clinicians with substance abuse experience, who worked in other programs at Genesis, worked per diem for us to help with the influx of clients and with randomizing them. Once we were able to get a few additional personnel doing

this, the operation ran smoothly. That's not to say it didn't get very busy at times.

Carroll: All four institutional collaborators had a lot to do with making sure the day-to-day flow of the study worked. We solved problems by brainstorming and achieving consensus. I can't say enough about the clinical program's willingness to help. When patients came in, they had to be told about the study, give their informed consent, get randomized, and be interviewed on the spot—all within 2 hours. That required cooperation from the receptionist through the clinicians who were participating and the executive director, too.

The clinicians actually came up with a lot of the solutions to the practical issues such as the need to have a standard interview clinician and one who was trained to do motivational interviewing ready at all times. What they said was, 'We can have both types of therapists available at these three or four blocks of time during the week. During staff meetings and Friday afternoons and Monday mornings—when things are hectic already—we are just not going to recruit for the study.' That worked very well. Having the clinicians and administrative staff involved in the problemsolving was important: They had some ownership of the study and were able to come up with a schedule that worked for them.

Impact of the Study

Caulkins: I think the clients benefited. These were folks who felt threatened about coming in and doing the evaluation, and I think having someone use the MET approach, rather than a confrontational approach, was good for them. We were more able to engage them in treatment.

In terms of the Genesis substance abuse treatment program, our approach may have changed some. I know my approach changed; it really helped me meet people 'where they are' in treatment. The skills that I learned, I have been able to

take with me and use while providing addiction services in prison.

Hyland: When we were through with this study, my staff continued to use the MET approach because they felt that it made a real difference in the clients' level of engagement. I have the MET training manual and share that with new staff members. We haven't lost sight of what we learned from the pilot project. We continue to implement it in our treatment.

Sheehan: On a systemic level, there has been an expansion of training in MET for both clinicians and DCF staff. Training was provided for clinicians in other agencies of the ABH network as well as our DCF social workers. Motivational interviewing also was incorporated into other programs whose goal was to increase engagement and retention, especially in treatment. Gains from the study proliferated throughout the system.

Libby: From my experience with CTN, where we are doing the MET study nationwide as one of the major protocols, I'm seeing significant impact on those clinics and the practices of those clinicians.

Lessons Learned

Sheehan: It always comes down to the people factor, that personalities are a good match. There was mutual respect, an important factor. The researchers were clearly empathetic and understood the types of challenges the study offered.

Libby: The key to making research in practice work is the ability to think 'out of the box,' to get outside of the paradigms that researchers and practitioners are used to, based on the needs of the clients. Each professional group needs to respect the expertise of the other. Flexibility is important, as well as being able to have a larger vision and being able to innovate.

Caulkins: I would be open to and willing to be part of another research project because I felt I benefited by getting to know some of the researchers and seeing what they are doing and their approach to things. My perception of research people had been of 'numbers' people who weren't really interested in clients. It educated me about who researchers were and what they were about. I was very impressed.

Beckwith: It was a valuable, positive learning experience. It gave Genesis the opportunity to be involved in research and to learn new techniques related to treatment that would help their clients.

Carroll: What was interesting about this project was seeing the realities a lot of the independent treatment programs are operating under—huge client burdens, not a lot of money or time. But they had this very impressive understanding of research issues. With the little practical problems that came up during the study, the clinicians were able to recognize some of the more fine-tuned research issues. If they had to make a decision on the spot and then check it out with us, they almost always made the right decision or knew when they had to call Bryce or me. They were very smart people who saw that this project could benefit their patients and that's why it was worth doing.

NOTE

Introduction and interviews by Robert Mathias, contributing writer, *Science & Practice Perspectives*. &