Implementing Evidence-Based Substance Abuse Treatment Services as a Cost Effective Strategy for Non-Profits

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Abstract

Not-for-profits provide essential services to rural communities and are therefore, key players in rural community development. The services they provide are funded by state and federal grants, and sometimes by philanthropic foundations. This paper addresses the challenges rural not-for-profits face in the world of competitive grant funding for substance abuse intervention and treatment services: fiscal and labor challenges and selection and implementation of evidence-based practices. Presented is a case study of one agency in an isolated and rural county that has been successful in securing federal grants for providing substance abuse intervention and treatment services to adolescents and adults. The paper is based on an evaluation activity conducted by the agency’s grant evaluator to assess the counseling staff members’ acceptance of, belief in, and perceptions of the efficacy of the evidence-based practice (EBP) they were required to use for their respective programs. The paper proposes that the ability to secure federal grant funding significantly contributes to rural community development. The selective use of evidence-based practices and the hiring of Bachelor’s level staff with little or no experience is a cost effective solution in rural areas that lack a formal substance abuse services infrastructure and trained health care professionals.

Key words: Implementation, rural non-profit, substance abuse treatment, evaluation, evidence based practice (EBP)
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The purpose of this paper is to address the challenges faced by rural not-for-profit agencies in the world of competitive grant funding for substance abuse intervention and treatment services. Not-for-profits can be a key provider of these services, but they must be able to secure funding and then find, train, and keep staff. Agencies also have to assure they can deliver quality services in sufficient quantity.

This paper presents a case study of one agency located in an isolated and rural county in Southwest Texas that has been successful in securing Federal grants for providing substance abuse intervention and treatment services to adolescents and adults. The case study is based on an evaluation activity conducted by the grant evaluator and Project Director to assess the agency’s counseling staff members’ acceptance of, belief in, and perceptions of the efficacy of the evidence-based practice (EBP) selected for use at the agency.

As indicated by Garner (2009), who conducted a comprehensive review of research studies to examine the diffusion of evidence-based substance abuse treatment programs, only 9 of the 25 studies examined implementation. Our evaluation project addresses this dearth of studies as well as provides a practical justification for the use of EBPs. We propose that for agencies in rural areas lacking in formal substance abuse services infrastructure and trained health care professionals, that careful selection and use of EBPs is a cost-effective and competitive solution for obtaining grant funding and delivering quality services.
BACKGROUND

Not-for-profits have to be concerned about the bottom line; the selection of intervention and treatment models and the requisite training of qualified staff involve significant costs. Rural areas face additional challenges because of the lack of treatment service infrastructure and often a constricted labor pool, that is, a lack of degreed individuals with an interest in the treatment field. Additionally, the labor market can affect an agency’s retention rate and voluntary turnover can be high, especially if there are alternative employment opportunities in the community for counselors with advanced degrees (Krecker, 1994).

The invested time, energy, and financial resources needed to implement an EBP can be significant (Hockenberry, Walden, Brown, 2007). Federal grantors in this field, namely, Substance Abuse and Mental Health Services Administration (SAMHSA), expects providers to use an evidence based practice model (EBP) but the costs for training, certification in some cases, and supervision for fidelity are financial outlays that a non-profit must consider from a fiscal point of view.

Selecting an appropriate EBP for one’s agency requires a good fit for both the community and the agency. Rural agencies in particular need to consider three key issues in selecting an EBP: (1) the local area labor pool; (2) the cost of buying the intervention/treatment model and the training required, and; (3) staff’s acceptance or resistance to evidence-based models. If the EBP requires Master’s level clinicians and there are few Master’s level counselors available, then that EBP will certainly be a poor fit. If the EBP requires travel and a lengthy certification process, it can be fiscally
prohibitive and delay implementation of the grant if, and when, funding is secured. If staff is resistant, then implementation can be fraught with difficulty.

Hockenberry et al. (2007) propose that creating an EBP environment or culture necessitates vision, engagement of the staff and stakeholders, integration into the existing structure, and evaluation to assure quality and measure outcomes (p. 222-223). At the center of their model are persistence, patience, and perseverance. There are a number of lessons learned from this case study related to these model characteristics and these will be shared in the discussion section of the paper. Hockenberry’s et al. model is recreated here:

![Evidence-based practice model](image)

**Figure 1.** Evidence-based practice model (Hockenberry, Walden, & Brown, 2007. p.223).
THE CASE STUDY

The particular area of focus for this paper is a county in Southwest Texas along the Mexican border that is both socially and geographically isolated; the nearest large cities are 2.5 hours away. According to the U.S. Census Bureau (2009), this county has an estimated population of 231,035. The area did not have a full-fledged four-year university until 1995 and consequently trained counselors with advanced degrees were hard to come by. Over the past 10 years, the situation has eased somewhat.

The agency upon which this case study is based has been in existence for over 25 years and has a successful track record in obtaining several large multi-year Federal grants to provide substance abuse intervention and treatment services. One of the unique aspects of this agency is its strong belief in the use of evidence-based practices (EBP). An EBP is one that has the best current scientific evidence of efficacy (Miller, Sorensen, Selzer, & Bringham, 2006). In the region where the agency is located, it is a pioneer in the implementation of evidence-based practices for combating substance abuse. The agency’s Federal grants for intervention and treatment services have been secured through the Substance Abuse and Mental Health Services Administration (SAMHSA) under the Department of Health and Human Services, Center for Substance Abuse Treatment, CSAT, and the Center for Substance Abuse Prevention (CSAP). SAMHSA strongly advocates for the use of evidence-based practices in the substance abuse field; therefore, the inclusion of an EBP in a grant proposal is a requirement.
DATA & METHODS

The data used for this paper is based on a structured survey instrument administered to counseling staff in five treatment and intervention programs. Questions used for the survey were derived from research of Nelson et al. (2006) who identified types of negative reactions practitioners have to EBPs and Kamhi (2006) who proposed staff skepticism of EBPs. Participation was voluntary and had no impact on their professional evaluation. Individual results were not shared with the administration to protect the respondents and imbue trust in evaluation at the agency. The key questions were as follows:

1. What does “evidence-based practice” mean to you?
2. Do you consider the treatment regimen of this EBP as: too short, too long, about right?
3. Do you consider this EBP treatment flexible enough to respond to your client’s needs?
4. What kind of training did you get in this EBP?
5. How would you characterize the training? (long, hard, short, etc.).
6. Was the protocol easy or hard to learn and implement?
7. If you have a question about the protocol or a specific client, do you have someone to talk to?
8. How would you rate your competency in using this particular EBP (scale of 1 to 10)?
9. How would you rate client attendance? (Percent perfect, adequate, poor?).
10. Does client attendance affect treatment outcomes, in your assessment?
11. Overall, how would you assess this particular EBP? (Have you seen it work? Does it work?).

12. If there was any one thing you could change about the treatment protocol, what would it be?

FINDINGS

Demographics & Background

A total of 15 unique counselors in five different programs were interviewed, for a total of 17 counselors interviewed for this case study (two counselors were interviewed two times for two different EBPs). Four are males, eleven are females, ranging in age from 25 to 49. One hundred percent are Hispanic. Fourteen of the 17 are bicultural as measured by Dawson, Crano, & Burgoon’s (1996) acculturation scale (the other three were not administered the scale). Their counseling experience ranges from 0 months (they had only been trained but had not yet implemented the treatment/intervention) to 22 years of experience. Five of the 15 counselors have Master’s degrees, two in psychology, two in criminal justice and one in sociology. The 10 undergraduates have degrees in psychology, sociology, and criminal justice. None are licensed professional counselors. Their EBPs range from 5 sessions to 34 sessions, plus intake. Four of the counselors were in an EBP requiring rigorous training and certification. The supervisor of these individuals also had to be certified.

Following, we present the outcomes of the survey for the twelve areas of interest. Given that the agency strongly advocates for EBPs, we first wanted to determine the
counselors’ level of understanding regarding the definition or description of what constitutes an EBP; we start there.

(1) Knowledge of EBPs

All but one counselor could adequately define or describe an EBP. Sample comments are presented here:

“Proven to work over a period. Shown to have positive outcomes. Effective tool for dealing with people with different problems.”

“That it's already been researched. Depending on the results that they have that it works. It's proven.”

The practice “…has been proven to be effective when used as it should be.”

“The therapies or techniques that we use come from research. They are appropriate and the expectation is to see results.”

(2) Perceptions of Length

Two of the three counselors using the short 5-session model felt that the treatment was too short. The other counselor felt it was just right. Of those counselors utilizing the 15 session models (not counting the two who had not implemented it yet), seven (71%) felt it was just right and two felt it was too short. Of the four using the 34-session curriculum delivered over about 4 months, all (100%) felt it was “about right.”

(3) Perceptions of Flexibility of the Model

All but one felt that the model they were using was flexible enough to meet the clients’ needs.
(4 & 5) Training

Of the two 15 session models, one required 2 days of training (plus weekly follow-up clinical supervision) and the other required 1 day of training. The short 5-session model required in-house training with the supervisors/local trainers gaining certification electronically. The 34 session model was primarily conducted on site (one of the counselors attended two national trainings), but all of the counselors indicated that training is a continuous process. Fidelity sessions were considered by these counselors as training. Five of the staff acknowledged that training is ongoing, pointing out that they have clinical supervision weekly. All but one of 15 counselors felt the training was adequate; this counselor had only 6 months on the job.

(6) Ease of Learning the Protocols

Counselors for the shorter model were split about half-and-half on perceptions of the ease of implementing what they had learned. Six felt it was easy, five felt it was hard, and one said it was “okay, but you have to study.” The four counselors using the long 34 session model were familiar with EBPs, having been utilizing them prior to using the longer one, and indicated because of this experience it was relatively easy to learn.

(7) Supervision & Clinical Support

All counselors readily replied that they could go to their program supervisor or the clinical supervisor for support, that there was an “open door policy” and someone was always available.
(8) **Self Assessment of Competency**

Three counselors rated themselves as very good (9 on a scale of 1 to 10 with 10 being the most competent). These counselors had 2 or more years experience working with EBPs. One of these counselors who self-rated as a 9, indicated that they had significant training, coaching, and fidelity checks. Two rated themselves as an 8 with one indicating that “I still need improvement.” Seven rated themselves as average (7), one rated themselves a 5, and one rated themselves a 4. The lowest scores were from individuals with 8 months or less experience implementing an EBP. One of these individuals with limited experience stated: “I’m still learning. I’m not where I want to be yet.”

(9 & 10) **Rating Client Attendance & Does Attendance Affect Outcomes?**

Answers varied greatly. There was no discernible pattern with respect to the level of counselor experience and the perceived rate of client attendance. It could be that some wished to please the evaluator. There was consistent pattern related to poor attendance. Almost all indicated that between 10 to 20% of their clients had poor attendance, with the remainder split between perfect and average attendance to widely varying assessments. All but one counselor felt that attendance affected outcomes. This counselor stated “No, not always.” “Yes, definitely” was a frequent answer.

(11) **Does the EBP work?**

All indicated that they perceived that the EBP worked at changing behavior. One qualified her/his statement by saying: “For kids who are focused, yes. For kids with
more dependency on drugs, no.” Another said, “Yes, if the family is involved.” Another said “I have so many success stories.”

(12) What Would You Change?

Three of the 15 counselors interviewed said they would change “nothing.” One stated that they did not have enough experience yet to suggest anything. For the short curriculum of 5 sessions, two of the three counselors wished they could add either a family session(s) or had the ability to add an optional session. As the counselor stated: “Every now and then clients need another session.” For the longer curriculum, two counselors wished they could add group sessions. Two others wished for an additional session(s) for follow-up on a taught skill or because “I think they need more time.” None expressed serious concern or frustration, and all adhered to the EBPs’ requirements/regimen.

DISCUSSION

As indicated in the beginning of this paper, we first wanted to present the evaluation findings regarding the staffs’ perception of EBPs and then use this evidence to discuss the success of the agency’s ability to implement EBPs for all their treatment and prevention services through the lens of Hockenberry et al.’s (2007) four component Evidence-based Practice Model.
Component One: Create a Vision for EBP

The vision of the agency was to deliver substance abuse services and SAMHSA is the main provider of funds for these services. SAMHSA requires its grantees to use EBPs. The agency started with one large grant in 2003 and that began the evolvement of agency organization and infrastructure to train and manage the grant, including the necessary data collection procedures required by SAMHSA. The key to success was selecting EBPs that require Bachelor’s level staff. Recent graduates with little or no job experience were a financial asset.

For their earliest grants, the agency selected EBP models approved by SAMHSA where training could be provided in-house or where the developer was willing to come to the site and whose model did not require a lengthy certification process. These EBPs required only Bachelor’s level staff, something the community could provide. Three factors: choosing a SAMHSA approved model; choosing a model that was manageable economically, because the training could be done on site, and; hiring Bachelor’s level staff was the beginning of the leap to even more success.

Another contributing factor to the agency’s success is the selection of EBPs that require either in-house training by a Master’s level clinician or a maximum 1 to 2 day training by the developer who is willing to come to the site, thereby limiting the cost of sending staff off to training and paying hotel, air fare, and meals. After three years of building capacity and experience, the agency received a grant to implement an EBP with significant training and a rigorous certification process for the counselors, supervisor, and clinical supervisor. This EPB was heavily subsidized by SAMHSA where the curriculum certification process was managed by the creator of the curriculum.
Component Two: Engage Personnel & Resources

The role of the clinical supervisor and program director responsible for supervision is also a critical key to the success of EBPs. As Nelson, Steele, & Mize (2006) found, practitioners claim that it is the lack of training and adequate supervision that is a problem with EBPs. One could argue the same for any service, not just EBPs. Adoption and training are first steps, but ongoing supervision is an absolute must for success.

Ideally, staff members should obtain training as a group from the developer of the EBP as this enhances cohesion and improves understanding of the model's philosophy and methods. As with any agency, there is always turnover and newly hired staff do not have benefit of this training. Keeping trained staff in a non-profit is a common problem. This agency’s main competitor is the public school system. However, use of an EBP lets new workforce entrants know exactly what is expected of them and reduces personality as a factor in evaluation, “leveling the playing field,” so-to-speak, and creating an environment where staff are treated equally. Agency commitment to EBPs creates a sense of being “special” in the community and that contributes to less turnover than would be expected.

Component Three: Integrate EBP and Nourish the Culture

Resistance by staff to an EBP is a common theme in the academic and professional literature. According to Nelson, Steele & Mize (2006) agencies, especially non-profits, may find that EBPs are hard to diffuse into their agency as many practitioners react negatively to their adoption. Reported objections are that practitioners prefer to use treatments with which they are more familiar. Staff can perceive EBPs as being inflexible. They claim that there is a lack of training and adequate supervision, and that
these treatments are not cost effective (Nelson, Steele, & Mize 2006). Adding to the
tentativeness of staff can be suspicions that the curriculum model was chosen just
because it was an EBP, not because it has been shown to work and had good/high-
level research evidence to support it (Kamhi, 2006, p. 321).

The glue that cemented it all together was the agency’s commitment to using
EBPs. It was through persistence, patience and perseverance, the sufficient factors in
Hockenberry et al.’s model (2007), that the agency evolved as a successful grant
obtainer. The findings of this study suggest that the agency’s dedication to the use of
EBPs for Bachelors level staff with no prior counseling experience, precludes, for the
most part, any concerns towards or negative reactions to EBPs. The use of EBPs is the
operating ethos of the agency. By embracing EBPs agency-wide, there is a shared
understanding of the philosophy of the agency. Hiring those with little counseling
experience but with high commitment, limits the bias of staff against EBPs, especially
since that is all they know. Thus, these individuals tend to demonstrate a high
acceptance of and belief in the EBP-model. The responses of the staff members to
evaluating their competency, issues of length of the EBP, and perceptions of EBP
flexibility, indicate a group of individuals who understand the models they are using, and
exemplifies a high degree of professionalism. Thus, staff members can suggest
insightful ways how the EBP might be improved, yet be dedicated to delivering the
model as outlined by the developers to assure fidelity.

**Component Four: Evaluate the Evidence**

“Are the staff doing a good job?” is an important question. If one is using an EBP and it
is being implemented as it is supposed to be, the outcomes should be as expected.
Most Federal substance abuse services grants require follow-up contacts at 3, 6, and 12 months after the completion of program services to determine if clients have changed their drug use behavior. These follow-up results are posted on the Government Reporting Results Act (GPRA) website. This agency’s results were equal to or better than other grantees. Even with Bachelor’s level staff with no prior counseling experience, this agency demonstrates that a not-for-profit can deliver both quality and cost effective services. Staff members’ perceptions “that it works, I’ve seen it work” are verified by the data.

IMPLICATIONS & LIMITATIONS

SAMHSA is perhaps, “the” technology transfer sponsor of psychosocial EBPs for substance abuse (Godley, Garner, Smith, Myers, & Godley, 2011). From a management perspective, we argue that no more than 10% of the overall grant budget should be allocated for the treatment model, including training. Some models can cost upwards of $8,000 plus travel. The first model used by this agency did not cost anything other than in-house time to learn the model and exchange tapes electronically with the developer. These two factors counter the objection that EBPs are not cost effective as found by Nelson, Steele, & Mize (2006). One of the newer grants at the agency required a lengthy (and expensive) certification process. Since the agency was already using the EBP in two other programs that did not require the certification, it had a distinct advantage compared to other grantees especially where training and documentation processes were concerned. Additionally, the training further enhanced the agency infrastructure and clinical supervision capacity. One could say they “just got lucky.”
However, the argument is easily made that selecting a curriculum approved by SAMHSA and used by other providers is a good starting point. Another consideration is to select an EBP that allows for staff to become certified trainers of other staff. Some developers require that they provide the training. Being able to train one’s own staff has obvious advantages. While determining the EBPs that other providers are using does take some investigative work, SAMHSA’s website facilitates an over-view of available EBPs.

While the quantitative results of treatment and preventions services (multiple services) are positive and compare favorably with other treatment providers’ program outcomes, the outcomes have not been analyzed for statistical significance. This evaluation activity is primarily qualitative. As Godley et al. (2011, p. 67) indicate in a recent article in *Clinical Psychology: Science and Practice*, “To date, there has not been a description or quantitative evaluation of a large federally sponsored technology transfer of a psycho social EBT for substance abuse treatment.” Their model, Adolescent Community Reinforcement Approach and Assertive Continuing Care was one of the EBPs included in this evaluation.

Certainly, there are management factors that can affect the success of a not-for-profit agency and these are outside the scope of this evaluation. What we can say, is that not-for-profits can compete for Federal funds by using appropriate EBPs that fit with their available labor pool and fiscal resources. Like any program, it takes administrative leadership and vision for success. In 2006, the agency was nationally recognized by SAMHSA for its dedication to evidence-based practices.

Lastly, we recognize the limitations of these findings. The not-for-profit agency presented here is culturally unique given that its target population is 95% Hispanic. The
population is not only Hispanic/Mexican American, but it has a significant number of newly arrived citizens who are not yet acculturated to the area. The population also has low levels of educational attainment and very high rates of poverty. For example, only 53% of adults over 25 have graduated from high school, and 26.8% of persons in the county live below the poverty level compared to 16.2% for the State of Texas (U.S. Census Bureau, 2000 & 2004). The census tract areas where many of the agency’s clients come from also show that significant percentages of adults do not speak English. The number of individuals 5 and older that speak a language other than English at home is 91.9% (U.S. Census Bureau, 2000). While culture can affect the delivery of EBPs in many ways, it is but one of many challenges to address in the provision of quality substance abuse intervention and treatment services in rural areas.
References


