Evidence-Based Treatments for Substance Use Disorders: Strategies for Successful Implementation

There are a number of empirically valid substance use disorder (SUD) treatments, including behavioral couples' therapy, cognitive–behavioral treatment and relapse prevention, contingency management, motivational enhancement and motivational interviewing proper, 12-step facilitation treatment, and brief interventions for alcohol use/misuse disorders. However, these interventions were largely evaluated for efficacy in the context of rigorous clinical trials, which may differ from typical community settings where comorbidities and treatment noncompliance are not uncommon. Thus, there might be some concern among community clinicians about the generalizability of empirical findings to everyday practice with everyday clients, which could result in poor adoption of evidenced-based SUD treatments by individual practitioners or treatment facilities. In 2007, this possibility was evaluated through the National Survey of Substance Abuse Treatment; the nature of current treatment practice in more than 13,000 eligible SUD treatment programs was assessed. Results indicated the use of evidence-based programming including relapse prevention, cognitive–behavioral treatment, motivational interviewing, and contingency management (90%, 69%, 56%, and 20%, respectively, endorsed usage as "often"). However, the challenges that specialty SUD treatment clinics encountered in the implementation of evidenced-based treatments (EBTs) or the routine use of these interventions over time is unknown.

The authors of the current study reviewed 21 publications that focused on the implementation process associated with the provision of new SUD treatments, or treatment outcomes after new SUD treatments were implemented, in order to learn more about correlates of successful implementation in specialty clinics. The review focused on implementation outcomes, effects of enhancements to training workshops, online training outcomes, implementation at the organization level, and common implementation barriers reported across studies. Results indicated that clinicians were generally positive about learning new interventions, but not all studies indicated that positive attitudes equated to changes in clinical practice. While some studies showed increased use of skills following training, those skills tended to deteriorate over time in 5 out of the 6 studies on the topic. However, 3 out of 4 studies indicated enhanced treatment outcomes associated with treatment implementation as compared with usual practice. All studies had a training workshop to assist with skill learning, and the majority offered subsequent training enhancements. However, enhancements were found to be incrementally beneficial to practice skills in only 2 of the 4 studies reviewed. Online training workshops, while potentially more convenient and less burdensome for the trainee, were associated with increased skills

that decayed over time in 1 study. In another study, online training was associated with lower therapeutic adherence and skills than an in-person training workshop. Results largely supported the benefits of organizational implementation on clinical practice of evidenced-based SUD treatments; however, sustained supervision over time may be necessary for the longer term maintenance of provider change. Finally, commonly reported barriers to implementation included a lack of organizational support, low organizational readiness to change, high staff turnover, poor provider motivation to change practices, excessive demands on clinicians' time, and heavy client caseloads.

How This Helps Practitioners: The use of EBTs for SUDs is becoming an increasingly common mandate among third-party payers. Information on the successful implementation of EBTs in community settings can help to inform clinical practice and assist clinics in making a transition in this area. Results of this study suggest the importance of organizational support for the implementation and sustainability of such a change. This organizational support would include the provision of in-person training workshops for clinicians and the availability of long-term support for change maintenance, including the provision of regular supervision and perhaps later expert consultation in the form of training boosters. Clinician compliance with new modalities should be monitored as a part of an ongoing supervision process. The literature on motivational interviewing might provide some direction in this respect, especially with regard to the evaluation of different training formats on provider skill decay and the various methods developed to monitor implementation progress and provide feedback to clinicians (e.g., the Motivational Interviewing Skills Code). More information on how to maximize the effects of training while limiting skill decay over time at an organizational level is needed. It is important for agencies to allow clinicians sufficient time in their workdays to devote to learning activities. Moreover, agency leadership should invest sufficient time in understanding how to implement organizational change while maximizing clinician interest and investment in the learning process and outcomes. Making implementation of new modalities maximally congruent with current theoretical orientations and practices may be helpful in this respect.

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