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RESEARCH TO PRACTICE BRIEF

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Children's Bureau

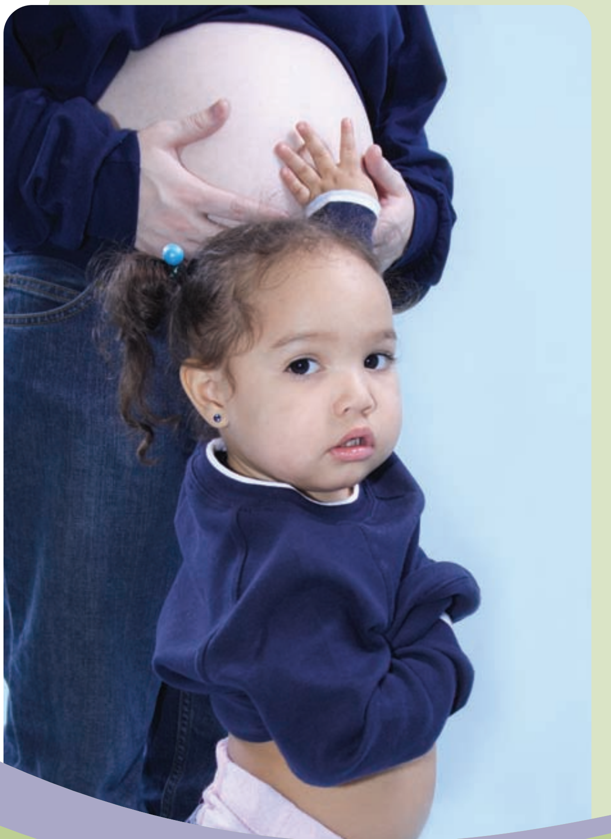
Service Engagement and Retention for Women with Substance Use Disorders

At 28 weeks pregnant, Alicia presents at the neighborhood health clinic with severe cramps. She has not received any prenatal care prior to this appointment. She has her three-year-old daughter in tow, and reports that the fathers of both children are in prison. She has no consistent living arrangement, moving from couch to couch as she overstays her welcome in friends' homes. She smokes an average of 1.5 packs of cigarettes a day, drinks a 6 pack of beer at least three times a week, and occasionally uses cocaine. The social worker is called in to assess Alicia, and finds that she grew up in foster care, and has no contact with her biological family. When asked if she wants to parent this baby, Alicia responds affirmatively. Knowing that Alicia is a high-risk case, the social worker attempts to gain Alicia's buy-in, asking her which services would be most helpful at this point. Alicia wants help obtaining MediCaid so she can access prenatal care more regularly, assistance finding housing, and a referral to an outpatient substance abuse treatment center. When the social worker checks Alicia's chart, she sees that Alicia made similar requests for services during her first pregnancy, and did not follow-through with those referrals. She and her daughter both tested negative for drugs at the time of delivery 3 years ago, and no further outreach was offered at that time. The social worker refers Alicia to a local nonprofit that works with pregnant and parenting substance users in an outpatient setting across town. Alicia receives a call from a scheduler, who makes an appointment for Alicia to meet with an intake worker onsite in one week. Alicia does not show up for that meeting.

Introduction

Statistics on engagement and retention specific to pregnant and parenting chemically addicted women are rare. For all men and women in outpatient substance abuse treatment, 30% of clients drop out within the first month,

and 50% or more drop out within the first three months (1, 2). There is some evidence of gender differences in retention rates: women demonstrated a 38% dropout rate compared to men's dropout rate of 25% at one month; and only 24% of women completed services compared to 46% of men (3). Although women who abuse substances do not necessarily need women-only services, treatment should focus on circumstances and issues that are specific to women. To address the needs of pregnant and parenting women who use substances and the needs of practitioners working with these families, this practice brief aims to outline specific engagement and retention strategies to decrease noncompliance and increase participation.



Client Barriers to Engagement and Retention

We know that women are less likely than men to seek treatment for substance abuse problems (4). We also know that women entering treatment often have less social support, and more child-related responsibilities than their male counterparts (5) which can affect a woman's ability or willingness to remain engaged in services. With the understanding that better outcomes are associated with receiving more intensive services (6), retention is a big concern. Numerous studies have suggested that engaging and retaining women in substance abuse services contributes to treatment success (7, 8). Predictors of better treatment retention for women include higher levels of income and employment, lower levels of psychiatric severity (9) and less severe substance dependence (10).

Women who are pregnant and/or parenting while using substances often have many life stressors including limited economic resources, low levels of social support, limited education and difficulties with housing stability. Additionally, they are more likely than non-substance-abusing women to have a history of childhood trauma, abusive relationships, parental substance abuse, and negative role models for parenting (11). Often as children, these women were exposed to chronic family violence, instability, and abuse (12). It is unrealistic to think that a woman will remain engaged in services if these issues have not been squarely addressed.

Women who use substances differ from men who use substances with respect to the antecedents for substance use. Women are more likely than men to start using substances following a traumatic event such as physical or sexual abuse (13, 14), are more often initiated into drug use by a partner who is also using (15), and are more likely to have a family history of substance abuse (16). Grossman and Schottenfeld (12) also found that women who abuse substances are frequently involved in problematic relationships with men who often provide limited emotional and financial resources and minimal parenting support. Additionally, women are more likely than men to have low self-esteem, high levels of guilt, and co-occurring mental health issues such as depression and anxiety (17, 18). Each woman should be thoroughly assessed prior to initiating services to ensure that her specific needs can be adequately and appropriately addressed, either within the agency or by referral. Having a contextual understanding of each woman's reason for using substances will dramatically improve the service provider's ability to retain and engage the client.

Service Barriers that Deter Pregnant and Parenting Substance Users

In addition to individual needs and characteristics (e.g., need for child care; history of trauma) that may deter women from initiating or remaining active in supportive services, programs themselves may present barriers that are especially difficult for pregnant and parenting women to overcome. In a study of programs' self-identified deficiencies, agency leaders identified areas for improvement in agency processes that could facilitate engagement and retention (19). These included:

- poor staff engagement and interaction with clients, including staff provision of outdated or conflicting information;
- dropped or non-returned phone calls by staff;
- incomplete descriptions of services and funding options;
- burdensome procedures and processes, including those that were slow or redundant;
- difficulties addressing clients' complex lives and needs, including missed opportunities to address language barriers and cultural-specific needs, family involvement, co-occurring disorders, court or welfare-involved client issues, and limited client resources; and
- infrastructure issues within agencies, including insufficient phone capability and run down facilities.

To address these issues, Ford et al. suggest minor improvements agencies can make such as reducing the time spent on assessment, having a person answer the phone rather than having answering machines or voice mail screen calls, reviewing intake procedures to reduce repetition and delays, ensuring confidentiality by providing assessments in private settings, and providing clear expectations so consumers know what they can expect from the service (19). It is also vital to provide services in the language that the consumer feels most comfortable.

Tactics for Assessing & Addressing Agency Barriers to Engagement and Retention

Given that there are many ways that clinics can improve services, it may not be clear where to start. Two strategies from the Institute of Healthcare Improvement (www.ihi.org) and the Network for the Improvement of Addiction Services (www.NIATx.net) that may be useful in helping clinics make changes are 1) the Walk-through and 2) the Plan-Do-Study-Act cycle (20).

Walk-through.

A walk-through is an easy way for clinic staff to identify problematic practices and processes and to answer the question of "What does it feel like to be our client?" (21). It involves a staff member literally posing as a client and "walking through" the intake procedures at your agency. Essentially, the designated "client" lets staff know that she/he will be going through the process as a typical family member (It's not necessary to make this a "secret shopper" event because deception may be harmful to achieving the goal of improving services). The "client" can then engage in services as clients typically do, such as by calling the agency and requesting an appointment, then attending an intake. The "client" should be documenting the experience during the walk-through by answering questions such as "What might a consumer be thinking?" and "How could we improve this process to increase client engagement?" After the walk-through, the "client" can discuss the experience with staff, and work together to decide how services can be improved to increase engagement. Examples of how walkthroughs can help agencies improve services can be found in Ford, et al. (19).

More information about the walk-through process is available at: http://www.ihi.org/knowledge/Pages/Tools/Walkthrough.aspx

Plan-Do-Study-Act.

The Institute for Healthcare Improvement promotes the Plan-Do-Study-Act cycle as a way for staff to:

- collect information to understand what problems need attention,
- identify a plan to improve the process,
- do the plan,
- study the information to determine whether the plan made an improvement, and
- make a decision about how to proceed.

Information about the Plan-Do-Study-Act cycles is available at: http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx.

The Plan-Do-Study-Act cycles are designed to be in rapid cycles, with minimal requirements for managing data. The idea is to try small improvements quickly, and keep what works. For example, staff can measure the number of no-shows that occur in a single week, then decide that they want to decrease that number by half (Plan). They implement a change in process, such as reminder calls the night before (Do), and measure how many no-shows occur during the week with the reminder calls (Study). By assessing whether no-shows were reduced, they can decide whether to keep reminder calls, modify the reminder calls, or do something else (Act).

Recommendations for Improving Engagement and Retention

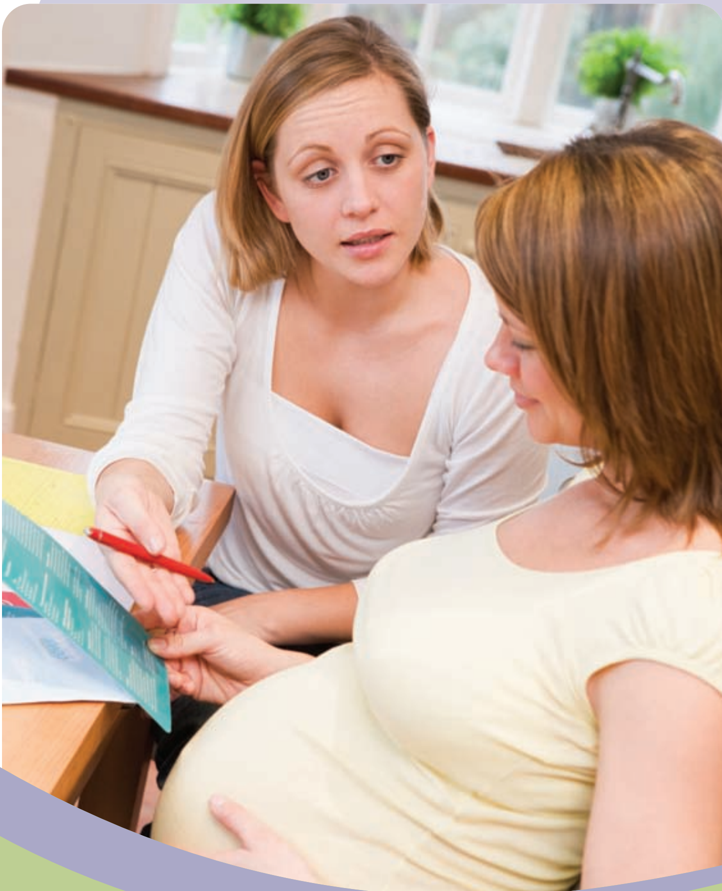
Below are specific recommendations that social services can implement to help improve retention and engagement for pregnant and parenting substance users.

Develop relationships early.

The quality of the therapeutic relationship and perceived empathy and helpfulness of the clinician is important to treatment engagement, and is associated with greater retention in services (22, 23). There are benefits to engaging the client the first day she walks into the office (24). Something as simple as changing intake procedures can help strengthen the relationship between consumer and clinician. Wisdom et al.'s 2009 study showed that having a single contact at the agency from the moment of assessment greatly reduces client anxiety, and increases feelings of being supported (24).

Manage or eliminate waiting lists.

Oftentimes programs have waiting lists, and are unable to admit new clients immediately. Unfortunately, during this time, some women choose to drop out of care before enrollment, get lost in the system, or are turned off by perceived inattention to their needs. Programs can take steps to reduce or eliminate wait lists by restructuring services to provide same-day assessment and intake. When wait lists are unavoidable, Wisdom and colleagues (24) found that continuing to engage women who were on the list by providing waiting list groups increased the client's connection to counselors and decreased the noncompliance rate when a space became available.



Use motivational strategies.

Motivational interviewing can enhance the engagement and retention of pregnant and parenting women in substance abuse treatment. Motivational interviewing is a brief, client-centered intervention that is directive and aimed at enhancing intrinsic motivation for behavioral change through addressing and exploring an individual's ambivalence (25). Integrating humanistic therapy with cognitive-behavioral treatment (26), motivational strategies include practicing empathy, providing choice, providing feedback, removing barriers, and clarifying goals. To implement these strategies, practitioners can:

- ask open-ended questions;
- use reflective listening;
- affirm change-related statements;
- listen and build upon self-motivational statements; and
- roll with resistance in a non-confrontational method (27).

Carroll and colleagues (27) found that when motivational techniques were incorporated into intake procedures, mothers who received the motivational strategies had significantly better retention through the treatment than those who had standard procedures.

More information about motivational interviewing is available at:
www.motivationalinterviewing.org

Understand and address individual barriers.

Another important factor in increasing engagement and retention is working with the client to understand possible barriers to treatment. Before services even commence, the provider can discuss with the client any possible barriers she may see to participating in services. To fully understand what is preventing a client from attending treatment regularly, it is critical that a practitioner follows up with the client each time she misses a session (28). For example, addressing a woman's childcare needs or transportation difficulties may be all that is preventing her from regularly participating in services. Assisting the client in finding affordable and quality childcare is key to increasing a woman's ability to attend services. If possible, agencies can offer home visits or, when this is not realistic, provide childcare onsite.

Place reminder phone calls.

For clinicians, practical strategies to increase engagement in treatment include the use of telephone reminder calls prior to the visit. On these calls, it is vital that the clinician uses an empathic style and problem-solving approach (29). Substance-using women often receive little positive support for their efforts in services, and reminder phone calls can both encourage attendance and aid in the therapeutic relationship. .

Provide continuous feedback.

Daley and Gorske (29) suggests that providing feedback about progress and regularly reviewing treatment goals can have a positive effect on hope, problem solving, and motivation. Providing direct and regular feedback allows the woman to know how she is doing, and how to further her progress to meet the agreed-upon goals.

Ensure a positive environment – both physically and emotionally.

A combination of aspects of the physical environment and staff attitudes and approaches can facilitate a positive environment that encourages therapeutic progress. Physical characteristics of the center such as soothing rather than institutional colors, quiet and well-lit spaces, and room structures that can be moved to allow privacy or encourage social interactions are associated with positive outcomes such as better discharge status, higher rates of client completion, and lower staff turnover (30). Women who have children would also benefit from spaces that allow children to play.

Women perceived the agency environment to be helpful when staff were particularly helpful. Staff attributes that contributed to this perception included: knowledge and experience, supportiveness, nonthreatening behavior, and availability (31). Women also stated that they wanted to feel unconditional caring, understanding and encouragement throughout services (31).

Engage women's partners.

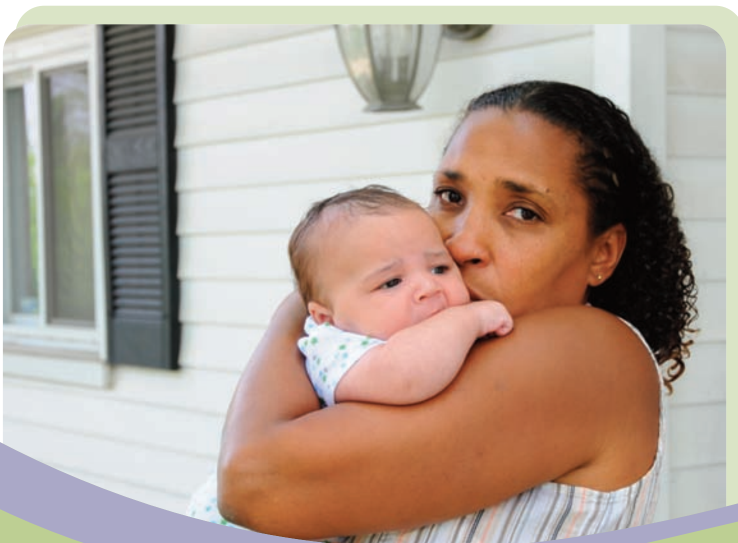
Service engagement among pregnant or parenting women may be highly related to their partners' attitudes and behaviors. Living with a substance-using partner decreases women's engagement and retention, and makes it more likely that the woman will relapse (32). However, if a woman's partner is also receiving services, she is more likely to remain abstinent and engaged in care (33). While difficult, obtaining partner support can be one of the most effective ways to increase engagement and retention in supportive services (34).

Address co-occurring disorders.

Effectively treating pregnant and parenting women's substance abuse problems may also require addressing co-occurring mental health issues, especially those that stem from traumatic histories (35). Trauma-informed service provision may work best for this population (36, 37). If the agency cannot address mental health needs onsite, suitable community referrals should be provided and followed.

Engage women in improving services.

Establishing a structure to solicit feedback from consumers on a regular basis both improves services and helps the clients develop leadership skills. One way to do this is by creating *a* "Resident's Council" or a "Consumer Advisory Board" to directly engage clients in improvement efforts. At this participant forum, members can discuss any concerns about the program and plan future activities. Issues can then be presented to staff at weekly meetings. This mechanism provides an opportunity for consumers to voice their concerns, for staff to be responsive to clients, and for an overall sense of community to be established by engaging clients and clinicians in joint decision-making about issues in the program (38).



Ensure services are a good fit.

Sometimes clients stop participating in services because the intervention simply doesn't work for them. If an agency provides an array of services, significant time should be spent during intake assessing what the client feels will be most helpful. Allowing the client to co-create the treatment plan will ensure client buy-in (39).

Conclusion

A planned, customized method of client engagement is a key component in getting a pregnant and parenting woman involved in supportive services, and is critical to retention. Since retention has been found to predict better client outcomes, it is vital that organizations and staff members take proactive steps to continually assess and create inviting environments that promote service engagement. Although pregnant and parenting substance users often present with substantial challenges to engagement, the strategies that have been offered here provide agencies with tools to minimize these barriers and improve engagement and retention.

References

1. - Palmer, R. A., Murphy, M. K., Piselli, A., & Ball, S. A. (2009). Substance user treatment dropout from client and clinician perspectives: A pilot study. *Substance Use and Misuse, 44,* 1021-1038.

2. - Simpson, D., Joe, G. W., & Brown, B. S. (1997). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11,* 294-307.

3. - Arfkin, C. L., Klein, C., di Menza, S., & Schuster, C. R. (2001). Gender differences in problem severity at assessment and treatment retention. *Journal of Substance Abuse Treatment, 20*, 53-57.

4. - Dawson, D. D. (1996). Gender differences in the probability of alcohol treatment. *Journal of Substance Abuse, 8,* 211-225.

5. - Wechsberg, W. M., Craddock, S. G., & Hubbard, R. L. (1998). How are women who enter substance abuse treatment different from men? Gender comparison from the drug abuse treatment outcome study. *Drugs & Society, 13*, 97–115.

6. - Hubbard, R. L., Craddock, S. G., Flynn, P. M., Anderson, J., & Etheridge, R. M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*, 261–278.

7. - Fiorentine, R., & Anglin, M. D. (1997). Does increasing the opportunity for counseling increase the effectiveness of outpatient drug treatment? *American Journal of Drug and Alcohol Abuse*, *23,* 369–382.

8. - Simpson, D. D., Joe, G., Rowan-Szal, G., & Greener, J. M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment*, *14*(6), 565-572.

9. - Mertens, J. R., & Weisner, C. M. (2000). Predictors of substance abuse treatment retention among women and men in an HMO. *Alcoholism: Clinical and Experimental Research, 24*, 1525-1533.

10. Green, C. A., Polen, M. R., Dickinson, D. M., Lynch, F. L., & Bennett, M. D. (2002). Gender differences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program. *Journal of Substance Abuse Treatment, 23*, 285-295.

11. -Pajulo, M., Suchman, N., Kalland, M., & Mayes, L. (2006). Enhancing the effectiveness of residential treatment for substance abusing pregnant and parenting women: Focus on maternal reflective functioning and mother-child relationship. *Infant Mental Health Journal, 27*, 448-465.

12. Grossman, J., & Schottenfeld, R. (1992). Pregnancy and women's issues. In T. Kosten & H. Kelber (Eds). *Clinician's guide to cocaine addiction* (pp. 374-388). New York: Guilford.

13. Grella, C. E. (1997). Services for prenatal women with substance abuse and mental health disorders: The unmet need. *Journal of Psychoactive Drugs, 29*, 67-78.

14. Nelson-Zlupko, L., Kauffman, E., & Morrison Dore, M. (1995). Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women. *Social Work, 40*, 45-54.

15. Amaro, H., Nieves, R., Wolde Johannes, S., & Labault Cabeza, N. M. (1995). Substance abuse treatment: Critical issues and challenges in the treatment of Latina women. *Hispanic Journal of Behavioral Sciences, 21*, 266-282.
16. Westermeyer, J. & Boedicker, A. E. (2000). Course, severity, and treatment of substance abuse among men versus women. *American Journal of Drug and Alcohol Abuse, 26*, 523-435.
17. -Ashley, O. S., Marsden, M. E., & Brady, T. M. (2003). Effectiveness of substance abuse treatment programs for women: A review. *The American Journal of Drug and Alcohol Abuse, 29*, 19-53.
18. Brady, K., Dansky, B. S., & Sonne, S. C. (1998). Posttraumatic stress disorder and cocaine dependence: Order of onset. *American Journal on Addictions, 7*, 128-135.
19. Ford, J. H., Green, C. A., Hoffman, K. A., Wisdom, J. P., Riley, K. A., Bergmann, F. L., & Molfenter, T. (2007). Process improvement needs in substance abuse treatment agencies: Results from walk-throughs of the admissions process. *Journal of Substance Abuse Treatment*, 33, 379-389.
20. Gitlow , H., Gitlow, S., Oppenheim, A., & Oppenheim, R. (1989). *Tools and methods for the improvement of quality*. Boca Raton, FL: CRC Press.
21. Gustafson, D. (2004). *Institute for Healthcare Improvement information gathering tools: Walk-through*. Retrieved from http://www.ihi.org/knowledge/Pages/Tools/Walkthrough.aspx
22. Joe, G. W., Simpson, D. D., & Broome, K. M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction, 93*(8), 1177-1190.
23. Fiorentine, R., Nakashima, J., & Anglin, M. D. (1999). Client engagement in drug treatment. *Journal of Substance Abuse Treatment, 17*(3), 199-206.
24. Wisdom, J. P., Hoffman, K., Rechberger, E., Seim, K., & Owens, B. (2009). Women-focused treatment: Agencies and process improvement: Strategies to increase client engagement. *Women & Therapy, 32*, 69-87.
25. Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford.
26. Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford.
27. Carroll, K. M., Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C...Woody, G. E. (2005). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*, 302-312.

28. Shwartz, M., Baker, G., Mulvey, K. P., & Plough, A. (1997). Improving publically funded substance abuse treatment: The value of case management. *American Journal of Public Health, 87*, 1659-1664.

29. Daly, D., & Gorske, T. (2000). Improving treatment adherence for mothers with substance abuse problems. *The Source, 10*, 1-5.

30. Grosenick, J. K., & Hatmaker, C. M. (2000a). Perceptions of the importance of physical setting in substance abuse treatment. *Journal of Substance Abuse Treatment, 18*, 29– 39.

31. Grosenick, J. K., & Hatmaker, C. M. (2000b). Perceptions of staff attributes in substance abuse treatment. *Journal of Substance Abuse Treatment, 19*, 273-284.

32. Gogineni, A., Stein, M. D., & Friedmann, P. D. (2001). Social relationships and intravenous drug use among methadone maintenance patients. *Drug and Alcohol Dependence, 64*, 47-53.

33. Riehman, K. S., Hser, Y. I., & Zeller, M. (2000). Gender difference in how intimate partners influence drug treatment motivation. *Journal of Drug Issues, 30*, 823-838.

34. Riehman, K. S., Iguchi, M. Y., Zeller, M., & Morral, A. R. (2003). The influence of partner drug use and relationship power on treatment engagement. *Drug and Alcohol Dependence, 70*, 1-10.

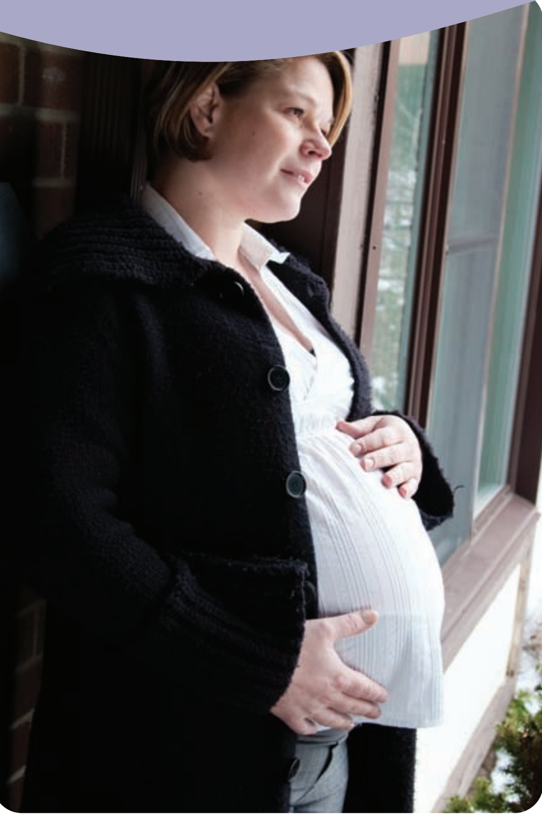
35. Grella, C. E. (1997). Services for perinatal women with substance abuse and mental health disorders: The unmet need. *Journal of Psychoactive Drugs, 28*, 319–343.

36. Amaro, H., Chernoff, M., Brown, V., Arevalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology, 35*, 845-862.

37. Najavits, L. M., Weiss, R. D., Shaw, S. R., & Muenz, L. R. (1998). Seeking safety: Outcome of a new cognitive-behavior psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437-456.

38. Network for the Improvement of Addiction Treatment. (2010). Boston Public Health Commission, Entre Familia: Project information. Retrieved from http://www.niatx.net/Story/StoryDetails.aspx?id=667

39. Pulford, J., Adams, P., & Sheridan, J. (2010). Responding to treatment dropout: A review of controlled trials and suggested future directions. *Informa Healthcare*, *18*, 298-315.



The National Abandoned Infants Assistance Resource Center's mission is to enhance the quality of social and health services delivered to children who are abandoned or at risk of abandonment due to the presence of drugs and/or HIV in the family by providing training, information, support, and resources to service providers who assist these children and their families. The Resource Center is located at the University of California at Berkeley, and is a service of the Children's Bureau.

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