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Women-Focused Treatment Agencies and Process Improvement: Strategies to Increase Client Engagement

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Behavioral health treatment agencies often struggle to keep clients engaged in treatment. Women clients often have additional factors such as family responsibilities, financial difficulties, or abuse histories that provide extra challenges to remaining in care. As part of a national initiative, four women-focused drug treatment agencies used process improvement to address treatment engagement. Interviews and focus groups with staff assessed the nature and extent of interventions. Women-focused drug treatment agencies selected relational-based interventions to engage clients in treatment and improved four-week treatment retention from 66% to 76%. Process improvement interventions in women-focused treatment may be useful to improve engagement.

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Following the passage of Public Law 94–371 in 1976, which directed the Secretary of the Department of Human Services to give special consideration to drug-abuse prevention and treatment projects for women and youth, the number of women-focused substance abuse treatment programs increased (Wetherington & Roman, 1998). In the past 30 years, the prevalence of drug treatment for women has improved significantly: about 87% of almost 14,000 drug treatment programs in the United States accept adult women clients, but only 32% of those programs offer specialized services for women (U.S. Department of Health & Human Services, 2006). Researchers and practitioners have increasingly turned their attention toward increasing the quality of drug treatment services for women (e.g., Marsh, D'Aunno, & Smith, 2000).

One effort to increase the quality of care demonstrated that that gender-targeted addiction treatment services may be more effective for women than mixed-gender treatment (Grella & Joshi, 1999; Campbell & Alexander, 2006), especially for women in the early stages of addiction recovery and for women who are also survivors of sexual abuse (Covington, 2002). Even within gender-targeted services, however, engaging women in treatment and removing barriers to enable them to finish the entire course of treatment can be difficult (Fiorentine, Nakashima & Anglin, 1999). Efforts to increase engagement in treatment while simultaneously improving services and retaining a gender-targeted focus have been challenging for women-focused drug treatment agencies.

In this article, we discuss strategies four women-focused drug treatment agencies developed to increase client engagement as part of an overall process improvement effort. We first provide background on gender differences in drug treatment, issues regarding engagement in drug treatment, and process improvement methods to increase engagement.

GENDER DIFFERENCES IN DRUG TREATMENT

Women with drug addictions present unique challenges in their treatment needs compared to men. For example, women are more likely to report histories of physical and sexual abuse than men (Moses, Reed, Mazelis, & D'Ambrosio, 2003; Molnar, Buka, & Kessler, 2001; Root, 1989), and women have higher levels of shame associated with their drug use (Bepko, 1991), which can also impede treatment. Women are more frequently initiated into drug use by their partners (rather than by friends, as is the case with men), and these partners are often their main suppliers during their addiction (Amaro & Hardy-Fanta, 1995). Women with drug addictions are more likely

than men to have co-occurring psychiatric disorders (Brady, Dansky & Sonne, 1998), face other barriers to treatment related to child-rearing responsibilities (Allen, 1995; Brady, Grice, Dustan, & Randall, 1993), and have more limited incomes, education, and job skills compared to men (Arfken, Klein, diMenza, & Schuster, 2001; Ashley, Marsden, & Brady, 2003; Green, Polen, Dickinson, Lynch, & Bennett, 2002; Hser, Huang, Teruya, & Anglin, 2003). Additional barriers to treatment exist for women of color, particularly for African-American and Latina women, due at least in part to cultural expectations, strongly defined family roles, and fear about stigma (Amaro et al., 2004; Heflinger, Chatman, & Saunders, 2006; Mertens & Weisner, 2000). Each of these factors can affect a woman's willingness to remain in treatment.

Women tend to have different experiences while using drugs or while in treatment. Women are more likely to face social stigma and discrimination related to their drug abuse than men (Copeland, 1997; Finkelstein, 1994; Grella & Joshi, 1999), they seek treatment at a younger age than men, and they are more socially engaged with employers and family than men seeking drug treatment (John, 1987). These social ties may impede treatment, as women with drug addiction are more likely than men to report partner opposition to treatment, including intimidation and threats (Amaro & Hardy-Fanta, 1995; Beckman & Amaro, 1986).

ENGAGEMENT IN DRUG TREATMENT

Although drug treatment is effective in reducing drug use, the attributes of what makes a particular therapy effective are not entirely clear (Anglin & Hser, 1990, 1992). It is commonly believed that a client's retention, treatment engagement, and success in recovery are primarily related to the initiative, desire, or perseverance of the client. Client engagement, as defined by the intensity and duration of treatment (Fiorentine et al., 1999), has been associated with positive treatment outcomes (Fiorentine & Anglin, 1996; Fiorentine, Anglin, Gil-Rivas, & Taylor, 1997; Simpson, Joe, Rowan-Szal, & Greener, 1995).

A relationship exists between the quality of counselor-client therapeutic engagement and length of stay (Joe, Simpson, & Broome, 1998); that is, better therapeutic engagement is associated with an increased length of stay in services. Furthermore, improvement strategies have been successfully utilized to increase retention and engagement (Simpson, Joe, Rowan-Szal & Greener, 1997). Previous research has linked length of time in treatment with successful outcomes in terms of decreased drug use, decreased criminal behavior, improved psychological functioning, and improved employment (e.g., DeLeon, Wexler, & Jainchill, 1982; Stark, 1992). Evidence also indicates that clients who complete treatment are less likely to relapse either during or following treatment (Fiorentine et al., 1999; Fiorentine et al., 1997), and those who are engaged in treatment are more likely to report favorable perceptions

of their counselors (Kasarabada, Hser, Boles, & Huang, 2002), specifically that their counselors care about their well-being (Fiorentine et al. 1999).

Despite these findings, there is little discussion of how specific approaches taken in women-focused treatment agencies accomplish these goals. Women-focused treatment agencies have initiated engagement efforts on a client-specific level that focus on the relational strengths of women—more specifically, that bonding between staff and clients and bonding among clients has been effective in increasing the length of stay of women in drug treatment (Comfort, Loverro, & Kaltenbach, 2000).

Success in substance abuse treatment for women has also been significantly related to changes from participation in mixed-gender treatment agencies to women-only treatment programs. To address programmatic barriers, women-focused programs have modeled treatment according to gender-specific needs, namely provision of child care services on site, domestic violence intervention, mental health and psychiatric treatment service provision, and linkages to medical care, housing, and employment services, often all provided in a "one-stop shopping" model (Sun, 2006; Hser & Niv, 2006). Data on women with co-occurring substance abuse, mental health, and trauma disorders from a large national cross-site study (Cocozza et al., 2005) demonstrated that treatment programs that offered inclusive counseling for these women's multivarious treatment needs demonstrated positive reductions in alcohol and drug use severity concerns and a decrease in mental health and posttraumatic stress symptoms.

PROCESS IMPROVEMENT AND ENGAGEMENT

Efforts to improve early client engagement are most successful when organizational factors at the clinical and organizational levels are impacted. Analyses indicate that extra-therapeutic factors contribute to up to 85% of treatment outcomes (Asay & Lambert, 1999). Examples of organizational processes include having case managers follow up with clients who do not show up for their scheduled appointments (Shwartz, Baker, Mulvey, & Plough, 1997), providing peer mentors for incoming clients (Godley, Godley, Dennis, Funk, & Passetti, 2002), and ensuring that clients are scheduled for their appointments in a timely manner (Gariti et al., 1995).

Process improvement, quality improvement, and related terms encompass a broad variety of definitions and interpretations. Over the past decade, process improvement has been successfully used by businesses and health care organizations to improve performance outcomes (Pearson et al., 2005). Broadly defined, process improvement is a method developed and tested within the field of continuous quality improvement that applies Shewart's (1939) Plan-Do-Study-Act (PDSA) cycles to improve organizational processes. The PDSA cycle demonstrates promise for improvement in drug

treatment (Molfenter et al., 2005) across all barrier levels, including systemic, programmatic, and client-specific concerns.

Another study highlighting the need for programmatic changes is the 2001 Institute of Medicine report on health care, which noted that the ways in which services are delivered are the real obstacles keeping patients from treatment (Institute of Medicine, 2001). Systemic and programmatic conditions controlled by the treatment facility account for up to 51% of the reasons clients cited for not accessing treatment (Joe et al., 1998; Ebener & Kilmer, 2003a, 2003b). The Institute of Medicine's 2006 follow-up report on mental health and substance abuse concluded that process improvement strategies are applicable to the treatment of alcohol, drug, and mental health disorders (Institute of Medicine, 2006). The Institute of Medicine report recommends efforts to (a) promote patient-centered care, (b) foster the adoption of evidence-based practices, (c) develop and use process and outcome measures to enhance quality of care, and (d) mandate the use of process improvement measures.

NETWORK FOR THE IMPROVEMENT OF ADDICTION TREATMENT

Starting in fall of 2003, 39 addiction treatment organizations from 25 states across the United States have worked together as members of the Network for the Improvement of Addiction Treatment (NIATx), a jointly funded initiative by the Robert Wood Johnson Foundation and SAMHSA's (Substance Abuse and Mental Health Services Administration) Center for Substance Abuse Treatment. Their purpose is to apply the principles of process improvement in order to quickly engage patients and retain them throughout the continuum of care. Participants learn to use limited resources more efficiently and share strategies and tools for improving access and retention in addiction treatment. NIATx process improvement coaches guide organizations into creating "cultures of improvement" in which patients and staff from all levels help drive treatment changes. The process improvement coaches assist agencies in identifying executive sponsors and agency "change leaders" who lead PDSA change cycles to improve services and outcomes. NIATx change efforts have four aims: (a) reduce waiting time between first request for service and first treatment session, (b) reduce the number of patients who do not keep an appointment, (c) increase the number of people admitted, and (d) increase retention by addressing client engagement. Through this iterative process of identifying problems and attempting short-term PDSA change cycles, NIATx agencies overall demonstrated a 39% improvement in timeliness (the number of days between clients' first service request and first treatment appointment) and an 18% improvement in retention (the percent of admitted clients who return for treatment) over the first 18 months of the project (McCarty et al., 2007).

Given women's unique treatment needs and the precedent of process improvement in improving engagement, this article describes strategies that women-focused agencies participating in NIATx used to address increasing engagement and aggregate results of their efforts.

METHOD

Participants

Although 39 independent addiction treatment agencies and five state authorities participated in the NIATx intervention, this article focuses on four agencies with residential women-focused treatment modalities from the first round of awards. Agencies were publicly funded, not-for-profit corporations and varied in size and location. Agencies were selected for analysis if they had a women-focused treatment program in which PDSA cycles addressing retention were conducted. PROTOTYPES (Pomona, California), Perinatal Treatment Services (Seattle, Washington), Step 2 (Reno, Nevada), and Entre Familia Program (Boston, Massachusetts) are included in this evaluation. Characteristics of these agencies are presented in Table 1.

Procedures

Research questions and semistructured interview guides were developed by the Oregon Health & Science University evaluation team. Using an iterative group process, interview guide questions were developed by the team with the goal of better understanding how agencies used the principles of process improvement to engage and retain patients. The study team used a multiple-case, explanatory-exploratory methodology to investigate policies, services, and change cycles undertaken during the study period. The explanatory strategy addressed "how" agencies approached the four NIATx aims; the exploratory strategy addressed "what" strategies were undertaken.

In-depth interviews were conducted by the team members, including the principal investigator and eight co-investigators. Qualitative data were collected from December 2003 to April 2005 via (a) quarterly telephone

TABLE 1 Agency Characteristics.

Agency	State	Annual number of clients	Staff	Interviewees
Entre familia	Massachusetts	153	30	10
Prototypes	California	10,000	285	9
Perinatal treatment services	Washington	206	56	6
Step 2	Nevada	119	32	10

interviews (n = 8), (b) annual in-person individual interviews (n = 12), and (c) annual in-person focus groups with staff members (n = 15) at the selected agencies. Of the 35 persons interviewed, 33 were women. Phone interviews averaged 30 minutes in length, while face-to-face interviews averaged about 50 minutes. Respondents were asked to provide information about specific process improvements they implemented using PDSA cycle changes, agency progress, outcomes, and barriers they experienced. All interviewees were informed about confidentiality, freedom to participate, and the right to withdraw from the study at any point. The Oregon Health & Science University Institutional Review Board for the Protection of Human Subjects approved the study.

Concurrently, participating agencies submitted monthly quantitative data, which tracked residential admissions and their retention rates. Retention for residential treatment was calculated as the percent of clients who remain in care for four weeks. Agencies submitted data on a rolling basis; we report average residential rates across the first three months of data submission (in fall 2003) and the last three months of data submission within the period of this report (in spring 2005).

Data Analysis

Qualitative interviews and field note documents were created for each interview, focus group, and change cycle report. All interviews were summarized and transcribed, and interviewer reflections were documented. ATLAS.ti 5.0 software (Muhr, 2004) was used to facilitate coding, organization, and retrieval of text for qualitative analysis.

Thematic codes were developed inductively as the transcripts were reviewed, allowing the data to dictate the analytic categories (Glaser & Strauss, 1967). After coding each transcript using 39 coding categories that were mutually agreed on by the first two authors, a series of automated text searches were subsequently run to cross-check several of the categories. The contents of each coding category and query were reviewed in detail by the evaluation team to ensure agreement on the nature of participants' responses to the interview questions. Common responses were highlighted and grouped, as were quotations that best illustrated the most common themes. Evaluation staff took several steps to increase methodological rigor: (a) multiple evaluators participated in data collection and analysis to ensure multiple viewpoints and discussion of perceptions of data, (b) evaluators sought consensus on coder agreement to ensure more accurate coding, (c) evaluators considered rival explanations while analyzing data to facilitate trimming and validating the theoretical scheme, and (d) agency representatives reviewed text to ensure clarity and provide detail when needed.

Quantitative data were analyzed for the change in retention from preintervention to postintervention using simple descriptive statistics. Data

for both qualitative and quantitative analysis are presented in aggregate form across agencies.

RESULTS

Results are presented that describe agencies' perspectives about engagement of women in drug treatment globally and chronologically in order of women's involvement in drug treatment. Thus, we describe (a) staff perspectives about the importance of recovery generally, (b) agency efforts to improve early engagement with initial staff interactions and before treatment begins, (c) efforts to increase engagement for newly admitted women through establishing "Peer Sister" programs and by providing incentives for sobriety, and (d) initiatives to improve engagement during treatment and after discharge by establishing close-knit, small cottages for enhanced bonding and alumni groups to encourage continued sobriety. Following staff perspectives and reports of agency changes to enhance engagement, we present quantitative results of clients' retention in treatment.

Staff Perspectives about the Importance of Engagement in Recovery

Agencies clearly identified the early stages of recovery as critical. One respondent said about her agency's clients, "The woman walking through the door [to seek treatment] is going through the most important moment of her life." As such, participants generally reported that early relationships, particularly at the assessment and early treatment stages, were key to engagement and retention. A respondent from a long-term residential facility observed that almost half of women admitted to their program dropped out before completing treatment, and most of those left within the first 30 days. She concluded that clients were having a problem connecting with treatment staff and decided her agency needed to "focus on what happened when clients came through the door." Staff were receptive to improving agency processes, recognizing that new clients "are often scared and upset, and everything's new for them." Another respondent noted that their efforts had been designed to ensure that the admissions process was "not an afterthought [but] an event" and a vital place to begin the engagement process. Agencies tended to report high dropout rates during the first week of treatment, a time when clients may lose their desire for treatment and leave against medical advice. New admits may be detoxifying from drugs at the time of their admission and may arrive during a time when few staff are available to tend to them. Agency staff awareness of these issues facilitated the engagement-related change projects.

Change Projects to Develop Early Relationships

Initial staff interaction

After identifying the initial contact as a critical time point for intervention, several agencies have focused on fostering engagement with their clients "the first day they walk in the door" so that "they feel that someone is connecting with them." In general, respondents felt that the lack of connection and "unavailability of staff" contributed to early client dropout.

In response, one agency implemented a change cycle to ensure that clients see clinical staff immediately upon admission instead of within two to three days, which had been typical at that agency. The agency established a system in which the new client had her first counseling session, met her child care worker and adult case manager, and was introduced to the environment, all within the first 24 hours of entering treatment. This immediate attention was most helpful for clients with children and were at risk for leaving treatment to be with their family. After the change was instituted,

> from the client's standpoint, intake is now more comfortable, and they are treated with dignity and personal attention. Having definite times to meet with appropriate staff helps reduce client anxiety about the treatment process.

An agency staff indicated she had received positive feedback about this process:

> [We] hear comments from the clients all the time that it's really good to have help right away upon admission. It reduces anxiety and reassures them that all is "in hand" and that they will get the attention they need while [here].

Overall, as a result of the early relationship development and interventions, "clients experience a very different treatment entry experience and more support in the period immediately following admission." One respondent reported that clients do not appear to be as "lost" during the first week as previous clients, and are displaying fewer disciplinary problems and lower perceived distress at intake.

Pretreatment engagement

Because of high demand for treatment, clients must often wait for a number of weeks to be admitted to treatment. It is not uncommon for clients to change their mind about wanting or needing treatment while waiting for entry to treatment. One agency found a way to utilize this crucial time by engaging clients in a "treatment readiness group." For this change, clients

on the waiting list come to the agency twice weekly to meet with their counselor for preliminary chemical dependency education and personal updates. They "bond with the counselor and one another" prior to admission and "seem more ready to come in when their names come up on the waitlist." Agency staff reported:

> By the time a person's name comes up on bed list they are already connected to [agency], so there are few no-shows.

Change Projects to Develop Camaraderie

Peer sisters

A different approach to encourage engagement involves facilitating clients' interaction with one another. One staff member indicated that clients "were having a problem connecting with other women in the [treatment agency] community," which she felt contributed to a low rate of retention in the first month. In response, three agencies focused on bolstering peer support through a "Peer Sister" program, which entailed linking a resident with longer tenure at the agency to a newly admitted client for support. One agency acknowledged that new clients had a complex routine to learn, and the peers helped significantly during this steep learning curve so new clients "don't feel lost." The Peer Sister gives the new client a tour of the facility, escorts her to her room to unpack and get settled, and remains available to her to answer questions and provide mentorship. Additionally, the Peer Sister writes the new client a letter describing the Sister's experiences of her first few days, providing hope and encouragement for her new peer. Selection criteria for Peer Sisters requires that the client has successfully been in treatment for long enough to demonstrate her trustworthiness. One agency required that the Peer Sister actually apply for the "job." They explain:

> This has increased the commitment level of the Peer Sisters because it's much more that they want to be a Peer Sister rather than being told to do the job, irrespective of interest.

The same agency found that Peer Sisters have been particularly effective during the weekends when counseling staff were not present. Staff felt that residents tended to leave against medical advice over the weekend to avoid staff efforts to intervene. Staff identified that "Peers can have a real influence during these times."

Peer Sisters receive training for their role and agency staff take the Peer Sisters out to lunch each month to provide supervision and encouragement. Additionally, Peer Sisters can take their mentee to lunch and movies, as

allowed. In addition to receiving positive feedback via evaluation forms from new clients, staff noticed a qualitative change in the client milieu:

> They notice that patients seem happier than they used to be, and staff also hear positive comments regarding Peer Sisters.

The Peer Sister program fosters engagement at three levels: first, incoming clients feel a sense of connection and welcoming to a new and perhaps somewhat inhospitable environment. They experience a sense of being taken care of and being "shown the ropes." Second, this relationship is fertile ground for the burgeoning of friendships and bonding between the two clients as they move through the program together. Last, the peer or "elder" sister feels a sense of accomplishment and fulfillment as she provides guidance to the new client.

> [We] decided to do this because it will provide a leadership opportunity for peers and allow the development of a core of leadership within the residents' community.

Staff found that this engagement practice has been effective, as one agency reported an increase in continuation for the first 30 days.

Change Projects that Provided Enticements

Contingency management

Another method of inducing engagement involved providing rewards for duration of participation. This is also known as contingency management and was incorporated by two agencies. Programs implemented contingency management by providing a certificate of attendance from the agency and a gift card to women after they attended four weeks consecutively, and then after three months and six months.

> It's a big hit for our female clients to receive their ten dollar Target gift cards upon completing their first thirty days in residence.

Other client incentives included an annual award:

> We provide a "Star of the Year" award for an outstanding client in recovery (from the alumni). Some were feeling like they couldn't get the award, so now they've added honorable mention awards, and the inpatient women see that and feel like it's something to work toward.

This agency also implemented "celebration awards" for finishing the first 30 days of treatment and "bravery awards" for beginning treatment,

which resulted in reduction of dropouts. One agency noted a potential downfall of incentive programs in that their peer of the month awards appeared to be a "double-edged sword." The "Peer of the Month," elected by vote of staff and clients, has lunch with a counselor off campus, so the award was coveted by clients. At the same time, it has seemingly created some resentment toward the recipient—some clients called it the "Suck Up of the Month" award.

Change Projects to Preserve Connections

COTTAGES

In order to increase engagement, an agency restructured their treatment units into small group "cottages" to increase bonding, both staff-to-client and peer-to-peer. The primary treatment facility that originally housed 120 women and 80 children was reorganized into four cottages with approximately 30 women each, in addition to their children. The residents subsequently created names and developed unique identities for each of their respective cottages. These cottages were then administrated by their own staff members, who held weekly cottage meetings at which residents could discuss treatment processes and raise community concerns. In addition to increasing opportunities for bonding in the treatment milieu, the agency further promoted monthly intercottage competitions (e.g., which cottage had the fewest number of newly admitted clients who left against medical advice), which also served to further the goal of increasing retention in treatment.

ALUMNI GROUPS

Clients who have successfully transitioned out of drug treatment offer a rich source of support and knowledge for one another. Agencies found that post-treatment groups were particularly important for keeping clients engaged with treatment staff and focused on their sobriety goals. They also were an important stepping stone for clients as they found themselves more fully integrated into their respective communities.

> Now alumni groups come in every other Tuesday and meet current clients. They talk about how they're managing now that they're back in the community, and what it's like out there.

For most agencies interested in alumni groups, however, they faced challenges in retaining former clients in any formal manner.

> We have some follow-up but not as much as we'd like. We do have alumni program that does dances and graduations, but we'd like to get them more involved.

> [State] has a high transient population coming and going. Also, clients who have been with us for three years [during the continuum of care the agency offers], they are sick of us! An alumni program is developing, but it is an issue we have struggled with as an agency.

Quantitative Results

Agencies reported monthly on the number of admissions to their residential programs and the percentage of those clients still in treatment at four weeks from admission while they were continually conducting PDSA cycles to refine and adopt the strategies described previously. Data reported are averaged for the first three consecutive months of data reporting; these data are from the time period August 2003 to December 2003, varying by agency. When commencing the project, four agencies reported an average retention rate of 66% (n = 129 clients). End of project data are reported for all agencies for the months of February, March, and April 2005. By the end of the project, women-focused treatment agencies reported an average retention rate of 77% (n = 134 clients).

DISCUSSION

Chemically dependent women have special characteristics and needs. Reviews of gender differences among drug-addicted persons indicate the importance of specialized treatment services in meeting these unique needs. Women-focused treatment agencies have found that initiating engagement efforts that focus on relational strengths of women have been effective in increasing the length of stay of women in drug treatment. Process improvement theory suggests that organizational factors can be helpful to increasing engagement.

This analysis examined how women-focused agencies made organizational changes by utilizing engagement techniques to improve the duration and intensity of clients in treatment while participating in NIATx. These findings indicate that agencies were able to design and implement successful engagement strategies that generally fit into four categories or themes: developing early relationships, cultivating camaraderie, providing enticements, and preserving connections.

Challenges

Making system-level changes to increase retention was not without its challenges. Decreasing the amount of time from first request for service to admission sometimes left residential clients without enough time to "put their affairs in order," creating anxiety regarding unresolved personal and family

matters and thus leading to decreased retention. Changes in one area sometimes disclosed weaknesses in other parts of the system; for example, increasing clients' engagement reduced unplanned departures, which then increased the waiting list, as it took longer for clients to cycle out of the programs. Finally, efforts intended to provide support and encouragement for clients worked for some clients and not for others (e.g., some clients' negative reactions to an agency's Peer of the Month award). Agencies making process changes should be attentive to the ways in which small interventions have multiple impacts.

Implications and Application of Findings

The results of this study support the premise that process improvement techniques can be a successful method of increasing client engagement and that staff focus on customer needs has the potential to improve the quality of care for women in treatment. The information gathered also supports the development of gender-specific engagement protocols. Despite the small sample size, the strategies implemented in these women-focused agencies may be applicable to agencies regardless of gender. From a therapeutic standpoint, attention to process improvement features that enhance delivery of care is warranted. From a fiscal standpoint, in today's competitive market for client patronage, increased focus on engagement techniques may play a key role in the success or failure of treatment facilities.

Limitations of Study

This analysis has a number of limitations. First, it is not a representative sample of treatment organizations in the substance abuse service system. Rather, the sample was drawn from women-focused treatment providers participating in NIATx. This sample procedure limits generalizability of study findings. Another limitation stems from the NIATx protocol itself in that sometimes agencies were implementing more than one change cycle at a time, which made attribution of success to one particular change cycle difficult. Additionally, because we do not yet have long-term outcome data, there is the question of whether these changes will be sustainable due to staffing or fiscal constraints. Last, although the engagement strategies were designed to be focused at the organizational level and therefore restricting the data collection to staff members was appropriate, the information gathered for this study comes strictly from a from staff perspective. Further studies would benefit from triangulating staff-level data with client input. However, there are also strengths stemming from the data set used. Although only four treatment programs were examined, these sites represent a large number of clients. Additionally, the sample represented demographic diversity, demonstrating that these techniques may be widely applicable.

Over the past decade, information on client barriers to treatment continues to highlight the need for systemic, programmatic, and client-specific adaptations in order to achieve desired outcomes and efficacy. From a gender-specific standpoint, our findings indicate that increasing the relational bonds between women, whether between clients or between clients and staff, has the potential to improve treatment engagement. Further research expanding on these findings will only serve to broaden the impact of knowledge generation within the field, but more important, to obtain the greatest likelihood of successful maintenance of recovery and sobriety for women across a lifetime.

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