

## **CHAPTER V. FOCUS GROUPS CONDUCTED WITH TREATMENT PROVIDER STAFF**

Focus groups were conducted from October 23, 2000 through March 23, 2001 to investigate treatment providers' perspectives and experiences during the implementation of the California Treatment Outcome Project. The focus groups were designed to inform mid-stream implementation modifications and the possible statewide "roll out" of the outcome monitoring system. Focus group discussions covered the treatment providers' typical services, approaches and practices, and staff perceptions of the implementation of CalTOP, including the changes that had occurred, what was working well, what obstacles remained, the type of help needed, and suggestions for improvement. (See Appendix C for the full focus group report entitled "Implementing the California Treatment Outcome Project [CalTOP], An Outcome Monitoring System for Substance Abuse Treatment Programs: Findings from Focus Groups with Treatment Provider Staff.")

This chapter describes the methods, participants, and findings of the focus group discussions held with CalTOP treatment provider staff. It also presents lessons learned based on the focus group data and limitations of the findings. The chapter concludes with a discussion of the implications of the findings for designing and implementing future outcome monitoring systems and other large organizational change efforts.

### **Methods**

Focus group participants were recruited from 43 of the 44 provider sites participating in CalTOP. (One provider had not begun implementation during the period of the focus group research.) The sites represented 25 outpatient drug free, 10 residential, 4 narcotic treatment, and 4 mixed modality AOD treatment facilities.

Focus group sessions were held in private rooms at the provider sites to allow staff to participate without having to travel. In some cases, staff from different sites were included in the same focus group to accommodate agency staff schedules, or to increase the size of the group as a way of facilitating a discussion among more than a few participants. This practice also permitted the researchers to both maximize the efficiency and minimize the costs of conducting the focus groups.

Each session began with the moderator and assistant introducing themselves and then welcoming the participants. After a copy of the Informed Consent Form (ICF) was given to each participant, the assistant read it aloud verbatim, describing the purpose, procedures, and confidentiality of the focus group discussion. Subsequently, participants were asked to remain in the group if they agreed to participate, and those who wished to decline participation were given an opportunity to leave the room. Five staff members at one provider site declined participation. Background information was collected from the participants through a brief pencil-and-paper survey questionnaire that did not include participants' names. Next, each participant was asked to select an alias to use during the session and ground rules for the discussion were presented (e.g., "you are free to answer the question in any way, as long as your answer pertains to the question; maintain confidentiality; respect each other's answers

and opinions”). Each session lasted between one-and-a-half to two hours and was audiotaped. The assistant also took written notes. The audiotapes were transcribed verbatim.

The data analysis process for the Focus Group Report included the development of a list of 35 primary codes and over 100 subcodes devised from the focus group topics and from themes that emerged through reading and rereading the transcripts. Transcript data were coded and organized for content analysis using the qualitative data analysis software program ATLAS.ti. Patterns in the coded data revealed overarching constructs and themes.

## **Participants**

In total, 28 focus groups involving 230 provider staff were conducted representing 43 CalTOP provider sites. Between 2 and 16 individuals participated in each focus group, lasting approximately two hours. The participants’ background questionnaires revealed the following: 64% of participants were female and 34% were male; 56% identified as white, 17% as Black/African-American, 16% as Hispanic or Latino, 5% as Multi-racial, 3% as Native American, 2% as Asian/Pacific Islander, and 1% as other ethnicity/race. Compared to the demographic distribution of administrators and counselors based on previous surveys conducted by UCLA/ISAP in drug treatment programs in Los Angeles County and California, the CalTOP focus group sample under-represents males (compared to 50%); slightly over-represents whites (compared to 50%) and is similar in its representation of Blacks/African-Americans, Hispanics or Latinos, and other ethnicities/races (compared to 18%, 22%, and 10%, respectively).

Sixty-nine percent of participants identified their job title as Counselor/Specialist, 15% as Administrator, 11% as Administrative Assistant, 3% as Data Processor, and 2% as Other. Participants identified their primary role in CalTOP as data collection/documentation/enrollment (58%), data processing (18%), implementation oversight/CalTOP contact (12%), none/not applicable (3%), and not sure/unknown (3%). They reported their highest education completed as: some graduate school or advanced degree (e.g., Masters, Doctoral) (20%), some college or college graduate (67%), high school graduate, including GED (11%), and grade school (1%). The number of years they reported working in the substance abuse field ranged from less than one year to 30 years, with a mean of 7 years, and the number of years at their current agencies ranged from less than one year to 23 years, with a mean of 4 years.

## **Findings - Major Themes**

A number of major themes emerged from the focus group discussions. Although they are presented as discrete topics here and in the full report (see Appendix C) they interconnect and overlap.

- ◆ Participants identified a client-centered ethos, which is built on a foundation of honest, trusting, respectful counselor-client relationships, as vital to treatment and recovery. This approach toward their work and their clients appeared to underlie staff perceptions of and experiences with the CalTOP implementation process.
- ◆ The time-consuming nature of CalTOP was the greatest challenge for provider staff who were often contending with scarce resources and already-full workloads. At many sites, the CalTOP work had to be accomplished in addition to county and in-house paperwork and

data entry. The aspects that were the most time-consuming included: the volume and redundancy of paperwork (both across CalTOP forms and between the CalTOP, county and in-house forms); initializing the automation system and entering data; lengthy intakes, often requiring multiple sessions to complete; frequent changes to forms and procedures; and the steep learning curve associated with the numerous CalTOP tasks (e.g., learning to administer the different assessment instruments, to document service elements, to enter and submit data).

- ◆ Staff buy-in was critical to the successful implementation of CalTOP, including the recruitment of clients into the follow-up study. The degree to which staff bought in appears tied to whether or not they received information in advance about the changes necessary for implementation, the value and benefits of CalTOP, especially for clients, and exactly how the confidentiality of clients would be safeguarded. In addition, staff appeared to buy in more readily when they were directly involved in the implementation process at their site.
- ◆ Hiring additional staff and/or assigning responsibility for CalTOP to one or two staff members typically made the implementation easier for the other staff at these sites.
- ◆ Many staff credited one or two people at their sites, often a counselor and an administrative assistant or a data entry technician, as instrumental to implementation. These key personnel appeared to have the requisite technical skills, expertise, and interest in assuming the particular responsibility, as well as the respect of their colleagues.
- ◆ Training appeared to influence staff buy-in, the quality and timeliness of the data collected and submitted, and client enrollment in the follow-up study. When staff received training in a timely manner and were given an opportunity to develop the requisite skills (e.g., typing skills, administering standardized assessments, and recruiting clients into the follow-up study), the implementation of CalTOP tended to progress more smoothly.
- ◆ Staff turnover presented ongoing training challenges for providers.
- ◆ Many staff encountered automation problems, from initializing the system to handling software glitches, that required more time and know-how to fix than staff had anticipated. CalTOP data entry was also time-consuming, no matter how the tasks were divided up at any given site. Other critical automation issues included: the complex design of the CalTOP system; the need for training; the value of key personnel who had computer skills or were interested in developing them; the need for additional or more advanced equipment; and the need for initial and ongoing assistance from ADP's Help Desk.
- ◆ Regular and timely feedback (e.g., monthly provider-specific status reports, information on where errors are occurring) was important in sustaining the momentum of the implementation of CalTOP and in submitting quality data on a timely basis. Participants also requested that more two-way collaborative communication be fostered between provider and research staff.
- ◆ Although focus group participants recognized the value of the standardized forms and procedures, they identified certain aspects of CalTOP's standardized system as undermining their client-centered ethos. The specific concerns included: (1) The lengthy and in-depth

CalTOP intake can draw attention away from the immediate concerns of the individual client, thereby disrupting the recovery process. (2) The numerous, required, and quantitatively-oriented questions on the ASI Lite can present challenges to building a treatment alliance. (3) The wording and content (e.g., illegal sources of income) of some ASI Lite questions can undermine counselor-client rapport. (4) Conducting assessments later in the treatment process (e.g., one month after admission), rather than at intake, with certain client bases (e.g., narcotic treatment, court mandated) may yield more accurate data. (5) Conducting assessments via computer tends to alienate some clients or raise their concerns about confidentiality. (6) Counselors wanted and needed to be able to exercise some discretion in conducting the assessments. (7) Enrolling clients in the follow-up study could be difficult due to client and staff concerns about confidentiality, especially at intake before a trusting relationship has been fostered. (8) The use of the same protocols for facilities of different sizes and modalities that serve different client bases might not be appropriate. (9) The service element codes do not capture all of the important areas of treatment, some of which may be impossible to quantify.

Staff wanted a standardized assessment system that has the ability to accommodate their facilities' modality and organizational structure, client bases, unique treatment approaches and programs, and client-centered ethos.

- ◆ In addition to the day-to-day tensions between research and practice that some participants experienced as they adjusted to CalTOP's standardized forms and procedures (outlined above), participants described other points of tension. These included that: research funds would be better spent providing treatment; CalTOP data could be misinterpreted or used to the detriment of provider sites; CalTOP might be undermining the effectiveness of treatment by placing research tasks on already-overworked counselors; and the amount of funds provider sites received for performing research tasks was inadequate. The lack of immediate, tangible benefits of CalTOP appeared to exacerbate staff's reservations about the project. A certain amount of tension between research and practice seemed almost unavoidable, given the treatment providers' client-centered ethos and the time-consuming nature of CalTOP in its pilot phase. However, staff did suggest ways to reduce tensions, including: have researchers study first-hand the negative effects of CalTOP at provider sites and devise ways to ameliorate them; involve line staff in the selection of standardized instruments; offer treatment providers more money per CalTOP client; and hire research assistants at provider sites in order to separate research and treatment functions.
- ◆ Whether or not staff perceived that there were any benefits of CalTOP appeared to affect how they experienced the implementation, including the level of staff buy-in and the degree of tension felt between research and practice. The immediate benefits that participants identified included: the CalTOP intake yields more comprehensive, in-depth information about clients which some staff find helpful in treatment planning and building a treatment alliance; participating in the follow-up study gave clients a voice in the treatment process; preliminary client outcomes were positive and clients' evaluation of treatment could improve the delivery of services; and the accountability CalTOP afforded was long overdue. In addition, some staff remained hopeful that the experience and skills they were acquiring through their involvement in the pilot study would prove valuable in a field that is becoming increasingly automated and outcomes-driven. Some participants also hoped that CalTOP data would document the many and varied services that they perform day-to-day, the

results and value of treatment, and the need for more services. This documentation, some hoped, would in turn be used to contribute to positive changes in the treatment field and in alcohol and drug abuse public policy, such as increased funding for treatment, rather than prisons, in order to serve greater numbers of clients more effectively.

### **Dissemination of Preliminary Focus Group Findings**

Beginning in December 2000, focus group data were analyzed to identify individual provider's training and support needs, and these were submitted to the California Department of Alcohol and Drug Programs (ADP) via Provider Support Checklists. In January 2001, CalTOP Focus Group Update, a preliminary analysis based on data from 23 focus groups, was sent to ADP and to treatment program directors, and also posted on the CalTOP web site. A presentation gleaned from the Update was made at the March 2001 CalTOP monthly meeting in Sacramento. Preliminary findings from the full focus group report were presented at the CalTOP monthly meeting held in Los Angeles in September 2001. In addition, some midstream changes (e.g., a shortened and simplified Locator form) and enhancements and fine-tuning by ADP and UCLA/ISAP staff, and key stakeholders have been made based on focus group findings and other sources of information (e.g., CalTOP monthly meetings, site visits by ADP personnel, phone calls with provider staff).

### **Lessons Learned Based on the Focus Group Data - Recommendations**

In addition to guiding mid-stream implementation modifications, a second purpose of the focus groups was to collect data to inform the possible statewide implementation of CalTOP. The "lessons learned" from the focus group data include both the strengths of the system already in place (i.e., mentors, monthly meetings, ADP site visits) and suggestions for improving or enhancing it. The intent of these lessons is to begin to construct guidelines that may minimize or alleviate problems, leverage the strengths of the system, and thus save time and money at all levels, should CalTOP or a similar OMS be implemented statewide. A comprehensive set of guidelines will need to be developed in dialogue with representatives of the key stakeholder groups (i.e., line and administrative provider staff, county and state administrators, and researchers). The recommendations are organized by topic. Other specific suggestions are detailed in the full focus group report, which is contained in Appendix C.

#### *Outcome Monitoring System Development and Design*

1. Involve both administrative and line staff at the provider level in the earliest developmental stages of the OMS including: defining treatment effectiveness; developing protocols; choosing assessment instruments, software and forms; designing the automation system; planning and scheduling training; and creating implementation timeframes, strategies, and plans.
2. Visit sites prior to developing implementation protocols in order to gain first-hand knowledge of the context within which the OMS will be implemented. Ideally, gather data on the day-to-day operation of a variety of facilities (chosen for size, modality, client bases, and treatment approach).
3. Take into consideration the different modalities, sizes and complexity of facilities, their treatment approaches and client bases, for example, when developing protocols, delivering training and setting goals.

4. Provide resources or funds to defray providers' up-front costs. Most provider sites may initially need to hire additional staff (e.g., a CalTOP administrator, data entry technician) and purchase the equipment (e.g., computers, Digital Subscriber Lines [DSL]) necessary to implement the OMS.
5. Coordinate, integrate, and streamline documentation and reporting requirements of the federal, state, and county governments, and researchers to minimize the burden on staff and clients alike.
6. Address staff concerns about client confidentiality and the ethics of OMS research prior to and throughout implementation. Develop a staff and client advisory committee.
7. Establish a communication network composed of: a telephone help line; a web site; email; advisory committees; monthly meetings of representatives from all of the key stakeholder groups; site-level mentors; and on-site visits and presentations by technical assistants, state administrators, and researchers.

### *Initial Implementation at Provider Sites*

1. Provide program directors and managers with accurate information, in advance, about the requirements of implementing CalTOP (e.g., time, staffing, equipment, skills, training) and the benefits to the agency, clients, and the substance abuse treatment field. Staff buy-in is vital to the implementation of an OMS.
2. Develop a plan that addresses staffing patterns, staff responsibilities, procedures, training, knowledge transfer, resources (e.g., equipment, staff, funds), identification of a mentor or point person, and impact on client services. Include staff at all levels of the agency in the planning process, focusing on areas of strength and need, so that the details can be worked out prior to implementation.

### *Training*

1. Provide initial training that is "hands-on" (e.g., practice using the assessments and forms, entering and submitting data on the computer) and available to all staff who would like to attend, if possible "in-house" or locally, close to the provider start-up date. Cover topics that include, but are not limited to: an overview of CalTOP, developing a site-specific implementation plan, conducting a training needs assessment, administering the Addiction Severity Index, Lite version (ASI Lite) and the California approach to American Society of Addiction Medicine Patient Placement Criteria (CA ASAM PPC), Service Elements, interviewing strategies, recruiting clients into the follow-up study, computer and data entry skills, and train-the-trainer. Some time should also be devoted to providing information regarding the design of each assessment instrument and addressing participants' specific concerns.
2. Identify a "mentor" at each site to serve as a CalTOP point-person, in-house trainer, and liaison with the state, the county, and researchers.
3. Offer ongoing training to accommodate staff turnover and newly hired personnel.

### *Automation*

1. Provide readily available computer/automation resources (e.g., technical experts, computer equipment, computer software) and support (by phone and email, and

- through on-site visits). Especially during the initial implementation stages, a walk-through with technical experts may save time and resources in the long run.
2. Make alterations to the client data retrieval system so that only the relevant client data are accessible. (Currently, records for a number of clients who are possible matches are retrieved.)
  3. Whenever possible, ensure that computer and paper forms match and coding schemes have continuity within and across the various forms.
  4. Offer treatment programs the capability to generate their own client and program level reports using data they have entered into their computers.

#### *Client Recruitment into the Follow-up Study*

1. Simplify and shorten the Informed Consent Form and the Locator form to make them more client- and staff-friendly.
2. Provide training or information on strategies for recruiting subjects.
3. Make the results of the follow-up study available to staff. If possible, provide site-specific information.

#### *Program Maintenance*

1. Revisit and revise the provider implementation plan periodically in order to accommodate changing circumstances.
2. Minimize the number and frequency of changes to the system once the implementation has begun.
3. Maintain all components of the communication network.
4. Provide staff with timely and useful feedback on how they are doing with respect to all aspects of the OMS (e.g., data collection/entry/submission, outcomes).

### **Additional Suggestions from Focus Group Participants**

Analysis of focus group data also produced a collection of staff suggestions for improving CalTOP, strategies for recruiting clients into the follow-up study, and ideas for improving or enhancing treatment programs and services for clients. These are detailed in the full focus group report contained in Appendix C.

### **Limitations**

There are a few limitations to the findings reported. Because the participants in the focus groups are not based on a random selection, the sample may not be fully representative of provider staff; thus, it is inappropriate to generalize from these group discussions to the general population of substance abuse treatment providers who are or may be implementing CalTOP in the future. For example, although staff from all of the four treatment modalities participated in the discussions, a few of the modalities and agencies may be over-represented in the findings because of the greater number of participants from those sites. However, the lessons learned from the data can help to guide the implementation of CalTOP or other major changes involving treatment provider staff, especially those that include research and/or technological change. These findings can highlight the possible barriers to implementation and suggest ideas to facilitate and support the change. Finally, the focus groups were conducted at certain points in

time with particular groups of individuals. Therefore, the findings must be considered within the context of what was happening at the time. Statewide and local changes, such as Proposition 36 (also known as the Substance Abuse and Crime Prevention Act, SACPA), staff turnover, increased familiarity with CalTOP procedures, and late mid-stream modifications, may have altered staff perceptions and experiences in significant ways since the time the focus groups were conducted.

## Implications

Intentional change is often a difficult and time-consuming process for individuals as well as organizations. The implementation of CalTOP was no exception. Given the dynamic and fiscally-constrained environment within which the CalTOP outcome monitoring system is being implemented, the new technology (e.g., computer automation, standardized client assessment instruments) and collaboration required by groups of diverse stakeholders, each with its own agendas, culture (e.g., norms, values), and expertise, issues such as delays, insufficient resources, and buy-in are not surprising (see for instance Backer, David, & Saucy, 1995; Camp, Krakow, McCarty, Argeriou, 1992; Hser & Anglin, in press; Klein & Sorra, 1996; Lamb, Greenlick, & McCarty, 1998, for information on the challenges of technology transfer and organizational change). In fact, other states participating in TOPPS II have reported issues similar to those that emerged from the CalTOP focus groups, including challenges associated with staff buy-in, staff turnover, automation and data transmission, and client confidentiality (see the SAMHSA TOPPS II Steering Committee report). While certain problems (e.g., computer glitches, procedural changes, delays) seem almost inevitable when testing the feasibility of systems, the perspectives and experiences of the line staff involved in the day-to-day treatment of clients and collection of data are invaluable to understanding the complexity and nuances of implementing an OMS as well as the human dynamics of change. This understanding is critical to inform and facilitate problem-solving, and is useful in developing guidelines for future outcome monitoring systems and other large organizational change efforts.

## References

- Backer, T. E., David, S. L., & Saucy, G. (1995). *Reviewing the behavioral science knowledge base on technology transfer*. NIDA Research Monograph Series, Number 155. NIH Pub. No. 95-4035. Bethesda, MD: National Institute on Drug Abuse.
- Camp, J. M., Krakow, M., McCarty, D., & Argeriou, M. (1992). Substance abuse treatment management information systems: Balancing federal, state, and service provider needs. *The Journal of Mental Health Administration*, 19(1), 5-20.
- Hser, Y., & Anglin, M.D. (2002). Making research relevant and beyond. Book review on *Bridging the Gap between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment*, Lamb S. Greenlick, M.R., & McCarty, D. (eds.), Washington, DC. National Academy Press, 1998. *Contemporary Psychology—APA Review of Books*, 47, 75-78.
- Klein, K. F., & Sorra, J. S. (1996). The challenge of innovation implementation. *Academy of Management Review*, 21(4), 1055-1080.

Lamb, S., Greenlick, M. R., & McCarty, D. (Eds.). (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment*. Washington, DC. National Academy Press.

Substance Abuse and Mental Health Services Administration (SAMHSA) TOPPS II Steering Committee. (n.d.). Treatment Outcomes and Performance Pilot Studies Enhancement (TOPPS II) Grantees Meeting – October 30-31, 2000 (State Reports: Problems and Successes with TOPPS II). Retrieved October 17, 2001, from [http://www.samhsa.gov/centers/csat/content/topps2/oct2000\\_statereports.htm](http://www.samhsa.gov/centers/csat/content/topps2/oct2000_statereports.htm)

