Readiness to Adopt Best Practices among Adolescents' AOD Treatment Providers

Anne Celeste Burke and Theresa J. Early

Social work, along with other human services professions, is increasingly moving to establish guidelines for treatment interventions that are based on empirical knowledge about populations, needs, and treatment effectiveness. This work, however, is in the beginning stages. This article explores how substance abuse treatment providers for adolescents attempt to obtain and use information to guide a "best practices" approach to treatment. Focus group data were analyzed for themes indicating supportive attitudes toward adopting and evidence of capacity to implement an evidence-based approach. Although support was fairly strong, capacity was relatively weak.

Key words
adolescents
evidence-based practice
substance abuse
treatment guidelines

In social work, as in many other human services fields, the call continues for standardization of practice and interventions based on empirical knowledge. Franklin and Corcoran (2000) noted that, "there are several viable ways to determine best practices (p. 40)," including opinion, expert judgment, and empirical evidence of outcomes. According to Rosen and Proctor (2001), other professional groups, such as psychologists and psychiatrists, are moving more quickly to develop practice guidelines. After an extensive debate on the merits and need for social work practice guidelines (Thyer, 1999), national and international conferences on social work research and evaluation have included presentations on developing practice guidelines (Fortune & Reid, 2001; Howard & Jenson, 2001; Potocky-Tripodi, 2000; Proctor & Bruno, 2001; Proctor, Rosen, & Rhee, 2000; Rosen & Proctor, 2001).

Proctor, Rosen, and colleagues (Proctor & Bruno, 2001; Proctor et al., 2000; Rosen & Proctor, 2001) focused on developing a standard structure for social work practice guidelines, which would include a "taxonomy of targets of change" as the organizing structure, a set of alternative interventions, criteria for choosing an intervention for a specific client, and information about the gaps in knowledge associated with each potential intervention. They also described a research agenda for developing the taxonomies of target problems and outcomes (Proctor & Rosen, 2001).

Two of the national presentations discussed the state of practice guidelines for specific populations and another focused on practice guidelines for culturally competent practice. Fortune and Reid (2001) identified intervention guidelines and protocols for family caregivers of ill older people for use in fields such as medicine, nursing, social work, gerontology, mental retardation, and psychiatry. Howard and Jenson (2001) concluded that few evidence-based guidelines are available for substance abuse treatment with adolescents. After identifying and evaluating several existing guidelines for culturally competent practice, Potocky-Tripodi (2000) called for social workers to begin using these guidelines and implementing rigorous evaluations of their effects.

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Given that practice guidelines are only beginning to be developed for social work practice and for many of the interventions involving social workers, how do practitioners obtain knowledge to inform their interventions? We explored that question with adolescents' alcohol and drug (AOD) treatment providers. We summarize barriers that AOD treatment providers face in obtaining and incorporating information into practice and make recommendations for systems change that would facilitate empirically based practice.

How do practitioners obtain knowledge to inform their interventions?

Substance abuse treatment for adolescents includes pretreatment (prevention), outpatient treatment at varying degrees of intensity, and inpatient treatment or residential care (U.S. Department of Health and Human Services, 1992). Outpatient treatment ranges from sessions of individual or group counseling at relatively infrequent intervals (that is, once per week) to several hours per day in an after-school or specialized day treatment setting. Treatment components include 12-step-oriented treatment (for example, Winters, Stinchfield, Opland, Weller, & Latimer, 2000), skills training and home-based case management (for example, Catalano, Gainey, Fleming, Haggerty, & Johnson, 1999), family therapy and behavioral training (Eddy & Chamberlain, 2000), parent training and case management (for example, Johnson et al., 1998), multisystemic therapy (for example, Brown, Henggeler, Schoenwald, Brondino & Pickrel, 1999), and other interventions.

METHOD

Design and Purpose

The purpose of this exploratory study was to identify how adolescents' AOD providers obtain information on which to base critical program elements such as which interventions to use and which outcomes to monitor. The study was conducted at the request of the state AOD agency in a midwestern state.

We used focus groups to collect qualitative data about the perspectives of various stakeholders around the state regarding best practices for intervening with youths who have alcohol and other drug problems. The use of focus groups allowed for the solicitation of views from key informants in the services system in a relatively short period. Moreover, the interactions among the participants, with various roles and interests in the AOD services system, enhanced the quality of information obtained. Furthermore, this method was chosen in anticipation of the opportunity to ground more quantitative measures of these planning variables to be obtained from a self-administered survey of service providers in qualitative observations (Morgan, 1988).

Sample and Respondents

Staff of the state agency purposively selected focus group respondents to obtain a cross-section of experience with different types of AOD treatment programs for adolescents and representation from different areas of the state. Three focus groups were held in August 2000 with 26 representatives of AOD treatment programs for adolescents and other stakeholders, including a staff member of a state association of behavioral health care providers and staff from the state juvenile justice agency, juvenile courts, and a county AOD services board with responsibility for local administration in this decentralized state AOD services system. All of the focus groups took place on the same day. The two held in the morning were each facilitated by one of the investigators, and the group in the afternoon was facilitated by both investigators. Per guidelines outlined by Krueger (1988) and others, each focus group had from eight to 10 participants.

A focus group protocol was developed to guide the conversation among the participants. The guide also was administered to the focus group participants immediately before the discussions began to prime members to respond about each topic. We collected the guides at the end of the session and included the written responses in the data analyzed. Other data analyzed were the focus group discussions recorded by facilitators on flip charts, the facilitators' field notes, and notes made by observers in the focus groups.

The written guide included questions in the following areas:

- how respondents keep up with new developments in the field and get the latest information on best practices for working with youths
- how respondents decide what practices are best practices for the youths served, including what criteria respondents use in identifying and selecting best practices and how

they take factors such as age, developmental level, gender, ethnicity, and presenting problem into account
- respondents' views on best practices across the "client career" of referral, screening, assessment, intervention, and follow-up
- what changes in youths' knowledge, behavior, or situation respondents look for to determine if interventions have been effective, including which outcomes they measure, how they measure outcomes, and how they use outcome information.

Analysis

A research assistant transcribed the notes, respondents' written comments, and discussion comments recorded on the flipcharts. These transcripts were then circulated among state agency staff who attended the focus groups as observers, to verify credibility of the data (Lincoln & Guba, 1985). To maximize consistency and trustworthiness, one investigator analyzed and coded the transcripts, focusing on identifying emergent themes.

A three-phase coding process was subsequently used to analyze the data. The first step was reading through the transcripts and taking notes on recurrent themes. A set of codes was developed on the basis of these themes and then applied to the transcripts. After the initial coding, all coded output was examined and decisions were made about how to combine conceptually similar or redundant codes. The data were then coded a second time using the refined codes. A technical report was then written presenting the information gleaned thus far, which was mailed to the respondents to fulfill their request that the information be shared with them and to serve as a member-checking mechanism (Lincoln & Guba, 1985).

The final level of analysis incorporated feedback from state agency staff and respondents, as well as an additional pass of coding, in which responses were examined for their analytic meaning in relation to the literature cited earlier on evidence-based practice and practice guidelines.

Results

Prerequisites to implementing an evidence-based approach to intervention are that the practitioners have knowledge, supportive attitudes, and resources. An attitude of support for an evidence-based best practices approach is necessary, but not sufficient. Practitioners also must have appropriate resources and the knowledge and skills to select and evaluate the information. The findings are discussed in relation to evidence of supportive attitudes toward adopting and the capacity to implement a best practices approach. A further theme in the data is information that could be used in constructing a taxonomy of targets of change for this population, as suggested by Rosen and Proctor (2001).

Supportive Attitudes

An important element of practice is obtaining accurate and up-to-date information about populations and effective interventions. Participants indicated that they use formal and informal sources to keep up with new developments in the field, suggesting a supportive attitude toward evidence-based practice. However, participants cast a wide net and may obtain much information that is not research-based. Formal sources included online and other publications, organization Web sites, conferences, workshops, and newsletters. Informal sources included peers in other agencies, other types of service providers, and clients.

Participants cited the importance of information from Web sites maintained by major national organizations focused on substance abuse issues, including the Substance Abuse and Mental Health Services Administration (SAMSHA), the National Institute on Drug Abuse (NIDA), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). Providers also acknowledged the value of information from state substance abuse and behavioral health organizations. Proponents of evidence-based strategies asserted the importance of research and evaluation literature about substance abuse treatment as well research in related fields such as education, mental health, and neurobiology.

Participants also reported using professional journals as sources of information about new programs and policies. Many participants reported that they receive one or more journals by virtue of membership in professional organizations or associations. Participants also valued newsletters, books, and regulatory or certification guidelines developed by state and national organizations. Several participants commented, however, that finding the time to review written materials was a significant challenge.

Focus group participants were mixed in their views about the extent to which guidelines for best practices ought to be established "from above" and applied across programs. Some participants offered

to become involved in an effort to develop a framework and guidelines for adopting best practices that could be applied to programs statewide; others focused more on the need to develop criteria at a programmatic level and proposed using program evaluations to determine the relevance of specific practice innovations for the youths they serve.

Measuring treatment outcomes is another indication of an attitude supportive of an evidence-based approach. Participants indicated that they gather information about a variety of "changes" or "outcomes" for youths. The most common indicators participants reported that they measure are changes in AOD use, although they identified other outcomes they track as well.

Capacity for Implementing a Best Practices Approach

Participants had little difficulty identifying strategies to obtain information in support of a best practices approach, but determining how to evaluate the information and decide which new practices or programs to adopt was a struggle. A few participants proposed using outcome studies associated with various practices as the primary basis for identifying practices worth adopting. Participants proposing this approach indicated they look to research "for a history of success." One of the challenges associated with use of this strategy is difficulty obtaining information relevant to specific target groups. Consequently, participants acknowledged the need, at times, to "adapt information on general issues . . . to the target groups served."

Other participants advocated an evaluative approach based on the development of a logic model or some other comprehensive conceptual framework from which to consider "new research and interventions." Some participants indicated that they rely on guidelines such as "promising practices" and treatment improvement protocols (TIPs) developed by national organizations such as CSAT/CSAP. Some participants, however, proposed more "ad hoc" approaches to evaluating what works, suggesting reliance on "trial and error," "what makes sense," or going with a "gut feeling." Others indicated that they believe in relying on their "personal experience as a treatment professional" or "consultation with other experienced treatment providers," especially those who are knowledgeable about "what engages and motivates youths."

Although many participants supported empirically based interventions, the criteria they reported using in selecting interventions included an emphasis on a new practice being consonant with interventions already used and their own determination that the new practice be in "the best interest of the client." Pragmatic concerns also influenced their decisions about which interventions to use, such as accessibility, how easily a new practice technique could be acquired by program staff, the likely community response, the likelihood of obtaining funding for the new program or practice, and whether new practices or programs fit existing expectations for levels of care and time in treatment. Some participants suggested that community problems might arise if they adopted a practice that deviated from a primary focus on abstinence as the goal of treatment for adolescents.

Participants reported using data from primary and secondary sources to measure treatment outcomes. Most participants indicated they relied on self-report data from youths who participate in treatment services; sometimes they also used collateral data from parents or other family members. Both self-report and urinalysis were reportedly used to monitor changes in AOD use. Secondary data from school personnel, typically obtained by reviewing school records, was also gathered by some providers. Agencies gathered very little follow-up information directly from youths after termination from treatment.

Informing a Taxonomy of Targets of Change

Interventions that participants used and considered to be best practices represented the full range of adolescent- and family-focused interventions described earlier in this article. Participants echoed many points made in the treatment improvement protocols (U.S. Department of Health and Human Services, 1992), such as the need for interventions to be individually tailored for youths on the basis of developmental level, gender, and ethnic group characteristics. Participants also noted the need for intervention to be flexible, increasing or decreasing in intensity according to changes in a youth's presenting problems and recovery process.

Participants identified an array of targets of change, involving various aspects or domains of life, as indicators of effective treatment that could be used in the development of practice guidelines. It is not surprising that desirable changes identified included changes in AOD use. Some participants characterized the desired change as "abstinence" from use of AOD as an indication of

treatment effectiveness; others included "decreased use of AOD." Most participants also looked for improvement in school performance, such as better attendance, follow-through on homework assignments, and improvement in grades. Some also noted that they expected effective treatment to result in improved behavior at school such as reductions in truancy and fighting, resulting in fewer detentions or suspensions. No further involvement with the juvenile or criminal justice system and the resolution of legal concerns were also important criteria for deeming treatment effective.

For some participants, the development of more positive peer relationships, in school and in other community settings, was an indicator that treatment was having the intended effect. Other participants also included improved family relationships and fewer problems with family members as outcomes of effective treatment, although participants also noted that not all youths have ties to caring family members who support and influence them in a positive manner.

Acquisition and improvement of personal skills, such as goal setting, coping with stress, and problem solving, were cited by some participants as outcomes of effective treatment. Finally, increased knowledge and acceptance by a client with an addiction that he or she has such a problem was noted as another indication of effective treatment.

Discussion and Implications for Social Work Practice and Research

These focus group conversations with practitioners provide insight into how easily an evidence-based approach to the adoption of best practices could be implemented by agencies providing treatment to adolescents with AOD problems. For the most part, attitudes expressed toward such an approach were positive, and participants were knowledgeable about appropriate sources of information about best practices for effective intervention. Focus group data revealed, however, that many practitioners rely on practice wisdom or gut feeling to inform practice in this area, as indicated by how they selected interventions. There was little evidence that these practitioners looked for treatment outcome studies; they relied on their own and other practitioners' experience and preferences of various groups. Given the ideologically driven nature of substance abuse treatment, however, the considerable acceptance voiced for basing treatment decisions on empirical evidence is heartening.

Although attitudes were favorable overall, there was little evidence of capacity to implement an evidence-based approach. This does not necessarily represent a limitation among the focus group participants but is an important reflection of the state of the art in this area. As Howard and Jenson noted (2001), the TIPs make an important contribution to development of guidelines for best practices, but more research is needed to reach the level of specificity required for guidelines. Thus, if the best information available at the federal level is inadequate, implementing an evidence-based approach is problematic.

The outcomes for treatment that participants identified as important reflect the literature demonstrating negative effects of substance abuse on young people. It seems that treatment is appropriately focused on the behavioral and situational factors that contribute to or are affected by substance abuse, including co-occurring problems such as juvenile delinquency. Although participants reported measuring outcomes, they did not identify specific instruments they used. Related work with substance abuse treatment providers for adolescents in this state system reveals that most often someone at the agency created a survey of some type to capture outcomes instead of locating a reliable and valid instrument. The lack of specificity among focus group participants in combination with related experiences suggests that measurement of outcomes probably is not occurring with the rigor necessary to demonstrate program effectiveness.

This conclusion regarding the questionable nature of outcomes measurement contributed to a decision by the state AOD office to issue a Request for Proposals for a major training effort to develop and implement an outcomes approach statewide to identify and disseminate information about evidence-based best practices for working with both adolescents and adults. Clearly, more than training is needed to enhance the capacity of AOD service providers to adopt evidence-based best practices. Respondents also suggested forming workgroups comprising service providers, consumers, parents, representatives from related service systems, and state and local AOD administrators to address technical, logistical, and political issues related to identification and adoption of evidence-based best practices. Accordingly, discussion is underway about the possibility of forming regional work groups in conjunction with and as follow up to training.

As guidelines are developed in this state and elsewhere, it is critical that they be publicized, debated, and further tested in venues commonly accessed by practitioners. Clearly, this process includes the research literature, but it also includes more practice-related journals, newsletters, and conferences. On the basis of participants' responses about how they get information, conferences and workshops for practitioners are a particularly important source of dissemination, and they can also be used as a place to develop a consensus among stakeholders about whether and how to adopt the use of standardized protocols across programs at local, regional, and state levels. Publication in accessible formats on the Internet could also facilitate practitioners' adoption, although some agencies still have little access to online technology. Although these dissemination approaches are not novel or unique, it is incumbent on university and other professional researchers to remember to publish their findings not only in the scholarly journals, but also in more accessible media. It is critical for competent researchers to publish in these venues, because otherwise less rigorously validated methods will be published to fill the void. Moreover, greater reliance on such mechanisms can enhance participation and collaboration among researchers and practitioners and facilitate advances of knowledge and practice in this area.

Limitations of this study include the small number of participants and the limited regional (that is, one midwestern state) representation. Also the invitation from the state AOD agency and the authors' association with an academic institution may have influenced participants to be more positive than negative in their comments about evidence-based practice. Even with these potential limitations, the study reinforces the need for continued development and dissemination of social work practice guidelines for effective intervention in this area. This study also suggests that if such guidelines are available, practitioners are likely to use them. **HSW**

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About the Authors

Anna Celeste Burke, PhD, *is associate professor, and* **Theresa J. Early, PhD**, *is assistant professor, College of Social Work, Ohio State University. Please address correspondence concerning this article to Dr. Theresa Early, 1947 College Road, Columbus, OH 43210; e-mail: early.22@osu.edu.* *The authors thank Dawn Anderson-Butcher for helpful comments on drafts of the article.*

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