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Research and Practice Collaboration: What it means to staff

By Dwayne Simpson, Pat Flynn, & Kevin Knight

Federal funding initiatives in recent years have emphasized reliance on "collaborations" between the scientific and service communities. In the drug addiction treatment field, examples include the NIDA-funded *Clinical Trials Network* (CTN) and *Criminal Justice Drug Abuse Treatment Studies* (CJ-DATS) projects. Such collaborations may offer staff at some treatment agencies bragging rights and it also may provide much-needed opportunities for specialized training to enhance services. To others, the experience may simply be "painful."

If done well, however, a collaborative arrangement can be mutually rewarding. Because funding usually is funneled through grants, research teams take charge of inviting or selecting service providers with which to collaborate. Participating agencies tend to be comparatively larger, more richly resourced, more open to considering innovations, and "opinion leaders" among peers. To the extent that this is true, unfortunately, it means that results from these studies might be biased in their generalizability.

When there is collaboration, staff members at participating programs (including their clinical supervisors) may not be sufficiently prepared or informed about these arrangements. Explanations given to staff mainly focus on being part of a mandatory uptake of "evidence-based practice" and related innovations. While the research teams focus primarily on science and evaluation elements of the collaboration, service providers are rightfully concerned about more than just implementing a new intervention and helping create a trail of evidence.

Both teams must keep in mind that the interventions developed and refined on the "frontlines of practice are embedded in dynamic, multilevel, adaptive organizational processes operating in a larger social and political context" (Phillips & Allred, 2006, p. 172).

While leaders for both the research and provider teams focus on coordinating this collaborative process, members of the service delivery and support staff often are overlooked and hold concerns about "what to expect." To improve the chances of effective innovation implementation, **some common questions we hear raised by staff** are addressed below regarding personal and program-wide preparedness, responsibilities, and benefits.

Are you ready?

Making a significant change in practice or procedure is usually difficult for individual staff members and for the organizational culture in which they work. Furthermore, as complexity of the change increases, the challenges escalate. It is therefore the responsibility of *formal – as well as informal – leaders to effectively engage staff and communicate the innovation plans*. Not just once, but repeatedly in order to help staff understand and sustain support for changes being implemented. New staff especially need this attention. If you or your co-workers want clarification or more information, do not hesitate to ask for it!

First, your "readiness" depends in part on having a mutual understanding with co-workers about your collective mission—including a common conceptual foundation for how the core elements of clinical services should fit together. What are the steps for using practical applications of assessments for client

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needs and treatment planning, how are specific interventions and support services meeting client needs and strengthening therapeutic relationships, and are measures of client performance and retention being used for monitoring progress (e.g., see Simpson, 2004, 2006)? Within this context, you should be able to see how innovations fit within the "big picture" and how they can be useful. Ask if you need clarification.

Second, preparations for program change should include staff self-evaluation of needs (with priorities), a plan of action, a guidance and support structure, and monitoring procedures (e.g., see Simpson & Dansereau, 2007). In other words, organizational changes follow a sequential process not unlike those expected for clients during treatment. Organizational functioning (as measured by collective opinions by staff) is, in fact, related to quality of services. Indeed, organizations rated more highly by their staff—e.g., with respect to resources, mission, communication, cohesion, openness to change—obtain better ratings from their clients regarding treatment satisfaction, participation, and rapport with counselors (Greener et al., 2007).

> ***"Organizational changes follow a sequential process not unlike those expected for clients during treatment."***

Therefore, systematic assessments of staff needs and interrelationships can make a difference in planning and implementing innovations that will result in higher quality services.

Ultimately, choosing to move forward with an "agreement to collaborate" is a *leadership decision*. Leaders must determine if there is adequate staff readiness for change, sufficient resources and technical skills to meet the challenge, and a well-functioning organizational climate to sustain the innovation over time. Leaders also must plan the overall process, including the steps for training, formal adoption, implementation, and sustained practice (Simpson & Flynn, 2007). Lack of attention to explaining, encouraging, supporting, and rewarding staff efforts handicaps the chances of success. Staff need to stay informed and leaders need to be prepared to engage them in the decision-making process, possibly by requesting to have staff representatives or "key players" more closely involved.

What will you have to do, and why?

All research and practice collaborations revolve around "precision" in innovation implementation and evaluation issues. To establish scientific evidence for effectiveness, strict study protocols are followed in relation to clinical fidelity and adherence, sample selection, group assignments, program retention, and assessment strategies. But it is left up to the staff at provider programs to carry out most of the groundwork. Thus, learning <u>what</u> to do is only part of the formula for success; the other part is knowing <u>when</u> and <u>how</u> to do it.

You can expect to receive *well-prepared training*, typically with written manuals and procedural guidelines. Training usually is comprehensive (with skills-training and role-playing exercises), conducted by highly experienced personnel sensitive to common client situations and clinical needs you face. If the "translation" from protocol to practice is incomplete, however, do not wait to ask questions.

In turn, *your delivery of the innovation* will be expected to be highly consistent with the training protocol. It frequently will include observational or other methods for documenting the accuracy and consistency of your performance (representing protocol fidelity and adherence). Do not be surprised to see someone looking over your shoulder at times.

Then there are the *requirements for record keeping* that must be met. Testing how the innovation impacts

on clients and program operations depends on having well-documented measures that are conceptually relevant, highly scheduled, and complete. Depending on the innovation, these records may be taken from client self-reports, clinical files for services delivered, and collateral information from official (e.g., biomedical or criminal justice) sources. Collecting this information may feel burdensome and may include new ways of obtaining data, such as applying electronic enhancements for scoring and storing assessments. Remember that widespread missing or biased data can result in a project meltdown, even in cases where the innovation implementation itself appears to have been excellent.

The reason for imposing strict procedures both on innovation delivery and records collection is to *establish scientific legitimacy of the innovation and generalizability* for the field. That is, programs interested in considering an "innovation adoption" should have assurances that its effectiveness is based on intrinsic value of the technique itself, rather than merely on having an unusually well-qualified staff or heavily-resourced setting for its delivery. If you feel "pressures to follow protocol," remember it is critical to the process and not about you personally!

What can you gain from it?

Evaluation research teams have not always scored well in providing user-friendly feedback to field-based treatment providers. Nor have they always listened to and effectively addressed core concerns from provider perspectives about treatment access, engagement, retention, and outcomes.

However, legitimate research and practice collaborations are *intended* to reduce gaps between researchers and providers by offering better "win-win" scenarios. The scientific payoffs hopefully will include evidence for "field-based practice" even when applied in the context of real-world barriers that routinely face health services delivery. Including a broad range of staff from different service providers in collaborative studies improves credibility and confidence about generalizability of the innovation. Staff members from participating programs also can help educate and influence members of their larger information network who may have interests in using similar innovations. This is ***research to practice!***

Finally, staff experiences in this type of research can improve personal understanding and confidence in how "evidence-based practices" are determined. It also can strengthen clinical appreciation for the importance of adhering to service delivery protocols for new innovations. In summary—

1. **Clinical staff** can receive up-to-date and *high quality guidance and training* for emerging innovations. This frequently includes training certifications or CEUs, along with well-organized manuals that describe the background, objectives, detailed procedures, and materials needed for implementation.

2. **Clinical staff** can benefit from *improved information about client needs and treatment progress,* thereby helping to make adjustments in treatment plans and smoother integration of interventions and related services. This likewise can influence the process of clinical supervision.

3. **Clients** can get better *feedback (in graphic and user-friendly format) about their own needs and functioning,* guiding clinical conversations with staff about progress over time (both positive and negative), personal accountability, and solution-based approaches to future therapeutic interactions.

4. **Program leaders** can assemble better *self-monitoring tools based on aggregated records that represent client needs and treatment performance*, sometimes calibrated according to unit-level service sectors as well as innovation adoption efforts.

5. **Program leaders** can promote their staff-level involvement and participation in the project as documentation of using "evidence-based practices" for consideration by funding agencies.

Comments from Collaborators . . . .

"Gateway Foundation values working closely with a research team that can give technical advice with a personalized and pragmatic touch. Such collaboration improves the quality of our services. For instance, we have adopted research-based client assessment protocols as a direct result of IBR's dissemination and implementation efforts, which work for us because researchers helped "fine tune" the parts that deal with diverse needs of our large treatment system. Our staff can see how this aids us to better match services to specific needs of our clients."

Michael Giniger
Vice-President, Corrections Division
Gateway Foundation
Houston, Texas

"Collaboration with a research team with field experience (like the IBR at TCU) has allowed us to gather and analyze data we never would have gotten on our own. We compared client functioning measures and their perceptions of services across different sites—along with staff attitudes about program operations. Best of all, comparable records from other service providers were provided by the research team so we could compare ourselves directly with external "real-world" results. With such rich data we are able to draw out some very specific—and very helpful—insights about our services. Sharing these practical findings with staff has helped us validate what we do and to dig deeper for needed changes."

Mark Yount
Quality Improvement Director
Stewart-Marchman Center
Daytona Beach, Florida

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What's New on the IBR Web

Advice for New Visitors: A guide for new visitors seeking addiction treatment resources at our IBR Web site.

MAJOR REVISIONS to Manuals and Forms sections of the IBR Web site: These have been rewritten for making logistical selections of our counseling session guides according to therapeutic applications, and describing assessments of client and organizational functioning more strategically in relation to stages of treatment process and innovation adoption. The former *Resource Collections* section is now replaced with **Evidence** for summarizing findings that support the use of the TCU treatment concepts and resources. New **Publications** are listed and described, including the upcoming special issues of **Journal of Substance Abuse Treatment** (Simpson & Flynn, guest editors) on innovation implementation studies, and **Criminal Justice and Behavior** (Simpson & Knight, guest editors) on offender assessments from CJ-DATS project.

JUST PUBLISHED: ***Treating Addicted Offenders: A Continuum of Effective Practices (Vol. II)***, edited by Drs. Kevin Knight & David Farabee, was published in July and is now available at http://www.civicresearchinstitute.com/tao.html.
It includes recent research developments on epidemiology, screening & assessment, innovative approaches, drug courts, mental health, & juvenile offenders.