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Barriers to Implementing Individualized Substance Abuse Treatment: Qualitative Findings from the CASPAR Replication Studies

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Abstract

Problem-to-services matching is critical to patient-centered care. Further, the extent to which substance abuse treatment is individualized to meet specific client needs is a key predictor of success and represents “best practice” in substance abuse treatment. The CASPAR Resource Guide, an electronic database of local free and low-cost services, is an evidence-based tool designed to help counselors easily and quickly provide offsite referrals to services not available in most community treatment programs to increase problem-to-service matching. This paper examines system-level barriers to using the CASPAR Resource Guide among 30 counselors and 21 site directors across 16 sites in two different studies. Results from qualitative implementation analyses found that key program components needed to support the implementation of this evidence-based practice (e.g., individualized treatment planning, individual treatment sessions, and individual counselor supervision) were lacking, which jeopardized successful adoption of the CASPAR research interventions and prompted a redesign of the studies in order to enhance each program’s ability to support individualized care.

Introduction

Matching client services to client needs is an important cornerstone to individualized or patient-centered care and a critical component of effective substance abuse treatment (Hser et al., 1999; McLellan et al., 1997; Friedmann et al., 2004). As outlined by National Institute on Drug Abuse (NIDA) in its second principle of effective substance abuse treatment, “Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society” (NIDA, 2009). In addition to being a principle of effective substance abuse treatment, the idea of individualized care is also consonant with the Institute of Medicine’s (IOM, 2001) six aims of high quality healthcare as well as with the National Quality Forum (NQF, 2007) consensus standards for the treatment of substance use disorders.

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The Computer-Assisted System for Patient Assessment and Referral (CASPAR) Resource Guide is an electronic database of local free and low cost services. It was developed to facilitate problem-to-service matching by helping counselors easily and quickly provide offsite referrals to needed services after completion of a comprehensive assessment and within the context of individualized treatment planning (Gurel et al., 2005). In addition to increasing problem-to-service matching, we believed the CASPAR Resource Guide could also enhance overall client outcomes by assisting counselors in finding services that might not be available onsite in most community treatment programs, such as health clinics, physicians, or dentists as well as job training, GED programs, childcare, and food banks.

We first piloted the CASPAR Resource Guide in a study involving nine treatment programs in Philadelphia. The success of this trial of the CASPAR Resource Guide (Carise et al., 2005) was encouraging and led us to initiate two replication studies. These projects, also designed to be implemented within the context of individualized assessment and treatment planning, were initiated in two different geographical locations, one in the suburbs of Philadelphia and the other in a 50-mile radius around Atlantic City, New Jersey. However, due to concerns about counselor participation and how often the CASPAR Resource Guide was being used by counselors who received it, recruitment for both of these projects was halted midway into the studies, and a formal implementation study was undertaken to investigate barriers to using the CASPAR Resource Guide. The following section provides additional background information on the CASPAR studies and the aims of the current study.

The CASPAR Projects

As noted above, the initial CASPAR intervention was developed and tested in nine treatment programs within Philadelphia (see Carise et al., 2005). This study randomly assigned treatment programs to either the CASPAR or a treatment-as-usual condition, and 18 counselors from 4 programs received the CASPAR Resource Guide as part of the CASPAR condition. Conceptualized as a clinical intervention for use by counseling staff, the CASPAR intervention was designed to help counselors better assess, engage and retain patients by helping them meet the expressed needs of their patients through training in comprehensive assessment (provided to both conditions) and additional training on individualized treatment planning and use of the CASPAR Resource Guide (provided to sites in the CASPAR condition). This project demonstrated promising results with respect to feasibility and client outcomes (Carise et al, 2005). Eleven of the 18 counselors who received training on the CASPAR Resource Guide made at least one referral using it. Clients whose counselors received the CASPAR Resource Guide: (1) had treatment plans that were better matched to patient needs identified at assessment; (2) received more services; (3) received services that were better matched to their needs; (4) were retained in treatment longer; (5) were more likely to complete treatment. It was also discovered that counselors in the CASPAR condition had significantly lower turnover during the six months of participation in the study.

Although the pilot was quite successful, it was not without limitations. As a pilot-project, it was small and relatively simple in nature. Only four outpatient substance abuse treatment programs in one city (Philadelphia) received the CASPAR Resource Guide, and although programs were randomly assigned to either the CASPAR or the control condition, no pre-intervention data were collected on client outcomes to rule out pre-existing differences that might explain those found between clients in the CASPAR or control conditions at follow-up. Additionally, data on client performance was only collected for the first four weeks after treatment admission and data on client outcomes were limited to attendance and discharge status. Finally, there was only rudimentary data on how and how often the CASPAR Resource Guide was used by counselors who had access to it.

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It was within this context that the two larger CASPAR replication projects were conceived (see Table 1). Both projects (hereafter called Project A and Project B) sought to expand the original CASPAR work in outpatient substance abuse treatment programs with more nuanced questions and measures as well as more sophisticated designs. One CASPAR study, funded by NIDA sought to expand this work primarily with drug dependent clients in suburban areas outside of Philadelphia (Project A). This study utilized random assignment as well as a pre- and post- test design (all programs were measured before and after CASPAR implementation), extended follow-up time frames (six months), and additional indicators of client improvement. A second, NIAAA-funded CASPAR project (Project B) sought to expand the work primarily with alcohol-dependent clients sampled in treatment programs in and around Atlantic City, New Jersey. This study utilized random assignment, similar to the original CASPAR study, but also included extended follow-up time frames (six months).

Although there were differences in the designs of these projects, both projects contained the same intervention (matching services to client problems identified at assessment utilizing the CASPAR Resource Guide) and hypothesized that clients whose counselors were exposed to the CASPAR intervention would receive better matched treatment plans and problem-to-services matching as well as receive more services and have better outcomes. Both studies included common measures, including methods to track how and how often the CASPAR Resource Guide was used.

Unfortunately, however, both projects ran into difficulties. Preliminary analyses of the CASPAR Resource Guide usage logs from the intervention sites in Project A revealed that, of the 9 counselors with available logs (11 counselors were trained to use the CASPAR Resource Guide, however Resource Guide logs were accidentally deleted from 2 counselors' desktops), 8 logged into the program and used it within the first three months of training. However, the CASPAR Resource Guide was used by these counselors an average of 6 times over an average of 4 separate days within this time. Because Project B study started later, there were fewer counselors who were trained to use the CASPAR Resource Guide. However, analyses of these counselors' logs showed even lower usage; only 2 of the 8 counselors with Resource Guide logs independently logged into the program. In sum, the CASPAR Resource Guide was being used much less than we originally anticipated, particularly given what we had learned in the original CASPAR study and what we knew about the needs of clients in the replication studies. Indeed, preliminary analyses of client data from Project A regarding treatment plan and service use matching hypotheses found no differences among clients whose counselors received the CASPAR Resource Guide training versus clients whose counselors did not receive it. We also had concerns based on informal conversations with counselors during trainings that they did not perceive any added value from the CASPAR Resource Guide intervention within the current context of their treatment programs.

Evaluation of the Implementation of the CASPAR Resource Guide

The data that we had collected theretofore on the CASPAR Resource Guide usage was limited to short answers on counselor feedback forms and anecdotal accounts gathered informally from counselors and directors. In order to elicit additional information about beliefs and treatment practices that could have inhibited utilization of the CASPAR Resource Guide, we requested and received permission from the Treatment Research Institute (TRI) Institutional Review Board (IRB) to formally implement a series of interview and focus groups to collect supplemental data from counselors and directors in both studies about the CASPAR Resource Guide and treatment delivered in their programs. Specifically, we sought to identify reasons why the counselors were not using the CASPAR Resource Guide at the level we had anticipated and to investigate whether treatment was delivered in

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these programs in ways that supported or inhibited the utilization of the CASPAR Resource Guide. We were particularly interested in the extent to which treatment planning was individualized to client needs as well as the extent to which organizational infrastructure supported the provision of individualized care and how this may affect the implementation of the CASPAR Resource Guide.

Methods

The design of the data collection effort included sharing our preliminary findings with counselors and directors at the participating sites as well as gathering additional data from them that might help us understand how treatment was delivered at their program. This approach was used to gather information about why our current intervention failed and how the design of the study might be changed to facilitate use of the CASPAR Resource Guide. We collected both quantitative and qualitative data, however our analyses in this paper pertain to qualitative data collected in focus groups and interviews with counselors involved in both CASPAR projects as well as their supervisors and agency directors.

Participants and Procedures

We intended to present preliminary findings to and gather data from all counselors at each site where we had recruited clients (N=18 sites; 10 from Project A and 8 from Project B), regardless of experimental assignment and exposure to the CASPAR Resource Guide. We also wanted to meet with agency directors who were involved during site recruitment or program managers who supervised counselors at the participating sites in order to gain their perspective on treatment delivery at their agency. Although we held meetings at each of our participating sites, we were unable to collect the qualitative data at two of the Project A sites because they were unable to allocate sufficient time for us to present preliminary findings and to collect additional data. Additionally, many counselors who originally enrolled in the projects had left their jobs, were promoted within their own agencies, or were not onsite the day of the interviewing. As Table 2 displays, qualitative interviewing took place with 16 sites (8 from Project A and 8 from Project B), 30 counselors (14 Project A and 16 Project B), and 21 site/program directors (8 Project A and 13 Project B).

Approximately 88% of sites were non-profits (n=14) and half of the sites (n=8) were accredited, either by the State or some other national organizations such as JCAHO or CARF. Sites in Project A tended to be larger (all Project A sites had a total capacity of 100 or more clients) and were more likely than Project B sites to report that that their primary source of funding was from private insurance. Project A sites were similar to other substance abuse treatment programs in Pennsylvania who took part in the 2008 National Survey of Substance Abuse Treatment Services (N-SSATS) with respect to organizational status, but a smaller proportion of Project A sites were accredited. Compared to substance abuse treatment programs in New Jersey who participated in the 2008 N-SSATS survey, a greater proportion of sites in Project B were non-profits and fewer were accredited (SAMHSA, 2008).

Following the presentation of preliminary overall findings, counselors and directors were informed that we had received approval from the TRI IRB to speak with them further about our results in the context of questionnaires and semi-structured interviews (or focus groups if more than one counselor/director were present). Counselors and directors then moved to separate rooms to hear more about the implementation study and to obtain their informed consent to participate. All of the counselors and directors who attended the meetings to hear the preliminary findings agreed to participate. We were also able to locate and interview (separately) a director and a counselor who participated in the study but were no longer working at the site at the time we presented our preliminary findings.

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As mentioned above, if just one counselor/director participated, we collected the information within the format of a semi-structured interview. If more than one counselor/director participated, the information was collected within a focus group format. All interviews and focus groups were tape recorded to allow for the research staff conducting it to follow the conversation with the participant more closely (without being hindered by note-taking) and so the exact content and character of responses could later be analyzed. Data collection procedures, including the consent process, usually lasted 1-1 ½ hours. All participants were compensated $25 for their participation.

It is important to note that not all counselors within a particular agency participated in the CASPAR replication study at their site. When we met with the site director to initially recruit a site to participate in the studies, we only required that at least two counselors be available for potential participation. Some allowed all of their counselors to be recruited, but some sites allowed just two to be recruited. Thus, the data that we collected from participating counselors at a site may not be representative of all the counselors at that site.

Instruments and Measures

Themes and questions addressed in the qualitative interview guide were designed to provide more detail regarding counselors' current practices and agency characteristics. Specifically, the interview guide covered assessment procedures, perceptions about clients needs for additional services, referral resources and referral procedures, treatment planning, and clinical supervision, as well as thoughts about the utility of the CASPAR Resource Guide and the feasibility of its implementation within the current structure of treatment at their agency. Using this format, we were able to explore attitudes and beliefs as well as potential procedural and structural barriers to implementing the CASPAR studies as they were originally conceived.

Data Analysis

Taped interviews and focus groups were transcribed by one research assistant using an agreed upon set of transcription conventions (MacLean et al., 2004) and independently checked by another research assistant for accuracy (Tilley & Powick, 2002). Any discrepancies found were resolved by consensus. Transcripts were coded using coding and cross-case analysis techniques outlined by Miles and Huberman (1994) using NVIVO qualitative data analysis software (QSR International, 2008). Initial codes were developed from the topic areas addressed in the question guide. The coding scheme was further developed as additional themes emerged from the content of the interviews (Crabtree & Miller, 1999). Three senior project staff completed all of the coding. All transcripts were coded by two different senior project staff members independently and compared to each other. Additionally, two transcripts were coded by all three senior staff members. Any coding discrepancies were discussed until consensus was achieved. After all transcripts had been coded, the passages contained within each code were analyzed and summarized to capture key findings across studies, sites, and participant (counselor versus director). Whenever quotes were used to exemplify topics or themes, care was taken to ensure that they represented the majority of views expressed (unless otherwise noted) and were taken from a variety of different individuals interviewed in order to represent, as much as possible, the voices of all participants.

Results

A number of important themes emerged from the interviews and focus groups conducted with counselors and directors at the sites participating in the two studies. These themes

highlighted a lack of individualized care as well as limited organizational infrastructure to support delivery of individualized care.

Lack of Individualized Care

Based on our prior work, we hypothesized that the CASPAR Resource Guide would increase service referrals by helping counselors match services not available onsite to client needs identified at assessment. However, based on results from the initial CASPAR study, we made a number of reasonable assumptions about how care would be delivered in these agencies in order for this to happen. For example, based on prior work with similar sites we believed that programs would conduct comprehensive assessments, use the information gathered during the assessment to develop the treatment plan with the client, and design individualized treatment plans to address clients' needs (all reasonable assumptions given NIDAs Principles of Effective Substance Abuse Treatment and prior findings from the initial CASPAR study). However, as we talked with counselors and directors at the treatment programs in the CASPAR replication studies, we learned that treatment was not being delivered in the manner we expected. Below we discuss what we learned with respect to (1) the linkage between the assessment and the treatment planning process, (2) barriers for counselors in developing individualized treatment plans, and (3) the extent to which treatment plans and the treatment planning process were prioritized in the delivery of client care.

Assessment and Treatment Plan Linkage—With respect to the assessment process, all but one site reported using a standardized assessment tool addressing potential problems in areas in addition to alcohol and drug use (e.g., medical, psychiatric, family/social, employment, financial assistance, legal, etc.). However, it was often reported that the staff member who collected the assessment information may not be the staff assigned to see the client for treatment services. For example, one counselor reported:

> "They [clients] make a phone call; whoever has the first available appointment, that's who [counselor] gets that assessment. And then depending upon when that person [client] is able to be seen, and what type of treatment they [client] need… that person [client] goes into that program. We [counselor conducting the assessment] don't necessarily take that person [for treatment]" (Site 4).

In fact, three sites reported having separate assessors, and one site reported using the assessment collected by the referring agency (e.g., drug court or child and family services), systematically ensuring that the assessor was not the same counselor developing the treatment plan.

Given that the person conducting the assessment might not be the counselor providing the treatment, most sites reported a treatment plan development process that involved one staff member conducting the assessment and developing a clinical summary, along with an initial treatment plan, while another staff member developed the comprehensive treatment plan at a later point. Although this might seem like the best possible solution to ensure that clients could be seen on their schedule rather than on a particular counselor's schedule, it invites a potential gap between the integration of a comprehensive assessment into an individualized treatment plan. For example, although this was noted by a minority of counselors (N=3), one counselor confessed "I don't have time to read the intake even prior to getting the client…" Another counselor at the same site added "We never have time to look at the intake before we get to talk to the client" (Site 12).

Barriers to Individualizing the Treatment Plan—An individualized treatment plan is one that is developed with input from the client. Although we learned that counselors and

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directors at all sites reported that the treatment plan was, at the very least, reviewed with the client, we also learned that it was rare that the treatment plan was developed with the client. This was especially true for sites 9–16 (the Project B sites). For example, one director remarked, "I encourage them [counselors] to do it [develop the treatment plan] with the clients; I suspect it's not always done with clients. I have a strongish suspicion that it's not always done with the client, but the client has to sign…" (Site 13). A counselor at another site remarked, "The majority of time [the treatment plan is done] in session but there's times where you need to get it done, the client hasn't shown up for their visit, so you make it up yourself…'Cause it's really standard" (Site 12).

Across both studies, counselors and directors at eight different sites (3 Project A sites and 5 Project B sites) reported a number of additional constraints placed upon the treatment planning process that seemed to limit the extent to which treatment plans could be individualized to reflect clients' unique needs. For instance some counselors and directors noted that the content of treatment plans often reflected priorities of the funders or of the agency itself. According to one director, "There are certain things that are grant driven, what they want us to put on the grant, which is like HIV education, nicotine education." She continued:

> "HIV, TB, okay that's one form they discuss and have the client sign. Nicotine education, even if they don't smoke, we give them information on secondhand smoke, and if they don't wanna quit and they say that, then we give them… we just ask them to be open-minded and listen to what we have to say, that's all, which is, something… They're supposed to attend group, go to 12-step meetings, they're really supposed to be doing that. …Oh yeah they have to have—address—relapse right away, at discharge we hafta say we have a plan for that" (Site 10).

Another director noted that, although treatment plans are individualized according to the assessment of patient need:

> "…there's basic things that the program philosophy dictates that should always be on the treatment plan…for example, all of our patients are expected, our expectation is that they attend at least three 12-Step meetings a week. That's our expectation. Do they do it all the time? No. But it's on the treatment plan because that's what our expectation is. Generally what it would, what we do here is that, whatever brought the patient to treatment, is probably the first thing that should be on the treatment plan. What initiated treatment. So that's pretty much true to most treatment plans, that's gonna be the number one problem" (Site 4).

Other counselors and directors noted limits on the number of items they listed on the treatment plan due to feeling like they needed to prioritize problems that could feasibly be addressed within the context of treatment. For example, one director remarked:

> "…Ok, but it depends, again, it depends like with the numbers and all that. I'm just putting treatment plans together to use right now; they use the top three things… just stay abstinent, get drug and alcohol information right now. That's basically what I do unless somebody's got a serious problem with something. If they come in with a psych problem and it's prevalent, it's noticeable, then it's gotta go on the treatment plan…" (Site 14).

Another director noted:

> "… Most of the other things [things other than drug and alcohol problems] don't go onto the treatment plan. Like if there's a legal issue, employment issue, or things like that. And again, I think it's again because we, this is brief treatment. There's only so many things you can do, ya know, in the half dozen sessions people

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> actually show up. You know the drop-off rate I think for all addictions is the same. So it's with all the best of intentions but if, ya know, time limits us and the clients limit us, ya know, we don't, we intentionally don't put those things on the treatment plan so it doesn't appear that we're not working on them. It's not that we're not, but we can't" (Site 8).

Although not the majority, 6 counselors and directors at sites across both studies (2 Project A sites and 4 Project B sites) commented on how treatment plans were often vague, standardized, generic, or, as one director described them, "too cookie cutter" (Site 14). A counselor at one site said, "…I don't think that they've [treatment plans have] been as detailed as I'd like to see them be, and I don't think that their [clients'] treatment plans have really addressed those issues as much as they're actually a problem in those peoples' lives" (Site 6). A director noted:

> "I think they're [treatment plans are] pretty standard, and it's one of those things that we're working on, but I just got my first few treatment plans from a new counselor [sound of rustling papers], and I'm just wondering how standard… yeah … that seems to be the trifecta… finding a job, getting off probation or parole… and staying clean and sober, yeah" (Site 13).

Another director remarked:

> "…when you have counselors who have been in their position for a long time or with an agency for a long time, there's a certain amount of assuming and laziness that takes place and wanting to just get paperwork done and letting go of the individuality. And so they get stuck in certain semantics, and you start seeing those semantics treatment plan after treatment plan after clinical summary that's like 'hey wait a minute' you know if I were to take this treatment plan and read it in a group meeting, would we be able to tell and identify who this patient is. Or could it be any one of thirty patients; in which case it's not an individualized treatment plan" (Site 3).

Counselors and directors attributed the lack of specification and individualization of treatment plans to heavy caseloads and numerous time constraints. As the director at Site 3 explained:

> "If you ask any counselor, they will tell you that the paperwork and the amount of paperwork gets in the way of patient time. And I think that there's just a push to get the paperwork done as quickly as possible so its not sitting on the back burner, therefore it becomes almost routine and robotic. And that's where the individuality is lost in getting to know that patient."

And, indeed, we did hear this from counselors. For example, one counselor remarked, "Yeah, treatment plans are obviously needed, obviously helpful. But they're a very ponderous, you know time-consuming thing that you know it's like the bane of this field, as you may know, is you continue to do more with the same 40 hours" (Site 5). Another counselor broke things down even further, "I've got 50 clients, ya know,12 or 13 of them I have to see once a week, the other 40 I have to see once a month, plus 4 intakes per week which are 2 hours a clip. Then I run 9 hours of group a week…" This counselor added that, "when I have two choices before me; meet the needs of the client or document, I always choose…the former" (Site 11). Another counselor reported, "I think when we're doing their treatment plans and their initial thing we're looking for the easiest way to do it in the shortest amount of time for time management" (Site 13).

Under-utilization of Treatment Planning—Likely due to these (and perhaps other) reasons, we heard from a number of counselors and directors across both studies (n=8; 3

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Project A sites and 5 Project B sites) that treatment planning was, as it was performed at their agencies, undervalued, underutilized, and left room for a number of improvements. For instance, one counselor remarked, "We don't put a lot of value in the treatment plan, so it's really just, to us, words on paper. And I know that's not ideal but that's… it's just words on paper" (Site 12). Another counselor noted, "…It is what it is, man. Treatment plans are a necessity, and you just do 'em and you move on" (Site 11). Counselors in another focus group (site 2) said, "The treatment plan is something I do because I have to do it…" The other counselor in the focus group interrupted, "The regulators make us have one". In a similar vein, counselors in another focus group at Site 7 remarked:

> "Well I do tend to think a little cynical; I tend to think treatment plans are almost a justification as to what we're doing here for the insurance companies. I mean, I know that's kind of a cynical view, but it's like here's what we're doing. Here's why you're paying us, and here's X, Y, and Z that we're doing and therefore you know that we're doing something worthwhile. But, as far as the actual paperwork making a difference to the client, they [clients] could care less about what's in our files".

The other counselor in the focus group added:

> "Yeah. For um state inspections, for--yeah treatment plans are required." In recognition of these sentiments among his staff, a director at another site summarized, "So the biggest struggle that I see in supervision is having somebody be able to have a plan when they're in there with the client and to deliver care based on some type of conceptualization of the case and what needs to happen or having some shared vision with the client of where we're going."

He continued that:

> "…getting them to see plans as relevant I think is the hard thing and what's supposed to happen is the very first time the clinician meets with the client after intake they develop the plan and that basically drives care and that includes everything that would happen here as well as what would happen in the community" (Site 12).

Believing that the CASPAR Resource Guide would help counselors match services to clients' needs (as identified at assessment), we assumed that programs conducted comprehensive assessments, used information gathered during the assessment to develop the treatment plan with the client, and designed individualized treatment plans to address clients' needs. Counselors and directors we interviewed at all sites confirmed that they did, indeed, gather data on a range of potential problems that clients could be experiencing in addition to their presenting alcohol and drug problems. However, as noted earlier, we also learned that it was often the case that person collecting this information was not the same person who might later be delivering care to the client and that the client was often not as actively involved in the treatment plan development process. From the qualitative data, we also learned about an additional reason for the gap between the assessment and treatment planning process. Specifically, we heard from counselors and directors that they felt limited with respect to what they could do with the treatment plan and, as a result, saw little value in it. The next section explores additional barriers to how treatment was structured at these programs that further inhibited the possibility of "matching" client needs to client services.

Limited Infrastructure to Foster Individualized Care

Individualized care requires an environment that fosters individual attention to clients and their needs and supports counselors in providing this type of care. In talking with counselors and directors, however, we learned that (1) clients received relatively few individual

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sessions, (2) counselors received relatively little individual supervision, and (3) counselors felt unable to perform duties required to ensure that clients' diverse needs were being met.

Lack of Individual Sessions—Across both studies, the primary type of service seemed to be group counseling while individual counseling seemed to be provided occasionally as an adjunct to group treatment. Counselors and directors at only 2 sites noted that they provided weekly individual sessions to their intensive outpatient (IOP) and traditional outpatient (OP) clients. In the Project B sites, individual sessions tended to be more frequent for IOP clients. For example, at Site 10, counselors noted that clients in the lowest level (OP) were seen individually only once a month. However counselor at this site noted that "if they need more or want more, that's up to them. Or, if we feel there's a need, we can request it, but it's a minimum of once a month." Another counselor at this site added that "Level II [IOP] is 2–3 [individual sessions] a month." In the Project A sites, IOP clients tended to get fewer/less regular individual sessions than OP clients. For instance a director at Site 5 estimated that, out of a total of 15 sessions for the IOP program, IOP clients received "on average, one" individual session per month and explained that individual sessions were "as needed; they always get a first one, and then as needed throughout the course of IOP" A counselor at another site reported something similar. With respect to how often IOP clients get individual sessions, she reported that:

> "So it's sort of when it—as needed. I think officially they call it every 45 days that they need to have an individual-their treatment plan will say and an individual every 45 days. So pretty much that means one individual in their IOP they want to see and that's usually when they sign the treatment plan. For me, sometimes it's more because, if they wanna talk to me afterwards about something, I'll just talk to them."

She added that "It's yeah, it's in general outpatient where they have one group and one individual" (Site 3).

Counselors noted a number of key barriers to providing individual sessions including programmatic requirements for a certain numbers of hours of group sessions at the expense of hours of individual sessions as well as time constraints for employed clients to attend individual sessions in addition to required group sessions and for counselors to provide individual sessions regularly given heavy group demands and high caseloads. For example, according to counselors at one site, IOP clients were scheduled to receive 7 ½ hours of group treatment each week. Further, at least 2 sites reported there was some question about whether counselors could bill for individual sessions for their IOP clients. However, these counselors reported that they still attempted to address their clients' individual needs despite this barrier. When talking about individual sessions for their IOP clients, counselors from one of these sites (Site 4) reported:

> Counselor 1: "There's no individual for IOP."
>
> Counselor 2: "But we do see people individual for IOP. It's not billable necessarily, but we see them because we do treatment planning, aftercare. If there's any kind of crisis for therapeutic treatment, we see them."

These counselors added:

> Counselor 2: "… it [individual sessions] can be very informal. Someone says, 'Can I talk to you?' and you're sitting there talking 20 minutes about their legal issue or whatever. Because remember, they're [IOP clients are] going to be in more crisis than someone in general because they just go out of in-patient, so they're struggling a bit more…"

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> Counselor 1: “But it’s absolutely true in the general outpatient program, you’re seeing somebody for group, but then you have a 50 minute individual session with them. You can go much more in-depth as to what’s going on because that is a pure individual session as opposed to IOP where you catch them a few minutes here and there.

Time constraints were another barrier for clients and counselors. A counselor at one site remarked:

> “I don’t have the access to them [clients]. They only come to me for group therapy, ok, that’s it. You’re gonna say to somebody ‘hey Joe, leave work an hour early so you can come in for an individual session.’ Ya know, I’m talking to them while they’re in their group, or in the car or whatever, or as they walk through the door or smoke break…” (Site 14).

Other counselors openly admitted to struggling to meet their clients’ individual needs. A counselor at another site remarked. “They [IOP clients] have an individual session at the beginning and then as needed. This counselor was quick to point out, however, “….but realistically, you know, that’s just like I’m telling you what, you can’t keep doing more with less, you just can’t.” She added that “…we can’t [do individual sessions with IOP clients] because we’re doing individuals for the OP [general outpatient]. And you know, you gotta eat, you gotta sleep” (Site 5).

Lack of Individual Supervision—Like their clients, counselors across both studies also lacked regular, individual attention. With respect to counselor supervision, like client treatment, most took place in a group rather than in an individual format. Although nearly all counselors and directors noted that clinical supervisors had an “open door policy” and were available whenever their counselors needed them, regular, weekly individual supervision was reported to occur for counselors at only 6 of the 16 sites. As one director noted, “Well, we should really be doing individual supervision every week with them, but realistically once every two weeks would be fine” (Site 14). Another director reported that group supervision happened twice a week and that counselors got individual supervision once a month. However, she added that:

> “They stop in here and say… “Can I talk to you about this case?” you know, and they’ll sit here for 10 minutes and we’ll go over their case… So I try to remember to write it down in my book (laughs) as supervision time, but sometimes I don’t always remember. But they all know that they can come in here anytime, so they do” (Site 10).

A director from another site reported that individual supervision was not even something that was scheduled, rather that “A couple of times a month, they’ll come and say, you know, ‘This is what’s going on. What are your suggestions?’…” (Site 6).

Despite this lack of regular contact with their supervisor, only a minority of counselors across three sites (one Project B site and two Project A sites) expressed a desire for more, or more clinically-oriented, supervision. In fact, counselors reported that the majority of supervision focused on client care, and only a few counselors felt that supervision focused disproportionately on “paperwork.” In sum, most counselors expressed that “supervision as needed” seemed to address their clinical needs. Insofar as supervision is a time to answer counselor questions, counselors reported that this occurred. However, to the extent that individual supervision could also be used to train counselors on evidence-based practices or to monitor and reinforce evidence-based techniques adopted by the agency, it is likely that this would be missed in 10 minute exchanges in passing and even in longer sessions at infrequent intervals. Further, although open-door supervision practices may be helpful for

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counselors during a time of acute client crisis, it is unclear how this mode of supervision might help counselors in treatment planning and the development of long-term recovery strategies for their clients.

Lack of Support for Referral and Linkage Activities—Matching services to client needs hinges on adequate assessment and treatment planning, as well as on referral and linkage to needed services not available at the treatment program. We were concerned that these sorts of referral and linkage activities, key components of case management, were not occurring among the sites involved in the CASPAR studies. The qualitative component of our implementation study allowed us to directly and indirectly assess potential attitudinal, philosophical, and structural barriers to problem-services matching and referrals in our sample of substance abuse treatment programs. For example, we were concerned that counselors might wait to access services for clients until they had achieved a specific length of sobriety or might view accessing ancillary services as enabling their clients. However, we found that most counselors and directors participating in the CASPAR projects saw the decision on when to access services and how much to help the client access them as something that was nuanced and needed to be determined based on a variety of factors and on a case-by-case basis. Further, counselors and directors at nearly all sites (n=13; 6 Project A sites and 7 Project B sites) viewed performing case management duties as something that was expected of them (implicitly or explicitly) as part of their job as a substance abuse counselor. For instance, one counselor remarked:

> "I believe that anything that a client asks, you deal with openly and honestly. If a client requests assistance with that, if it's not in the building, or I don't have an answer, then I'll let them know that I will assist them in finding an answer. But they're here, and they're reaching out, so my responsibility is to respond to each request one way or another" (Site 1).

Another counselor said, "I make the referral, the suggestions, the phone numbers. In some cases, I will take them to those places; that's part of what my job is in the intensive outpatient program…" (Site 16).

Rather than finding attitudinal barriers, we found structural barriers preventing counselors from under-taking case management activities. Many counselors felt frustrated because there seemed to be little time and little incentive for them to do the sorts of case management activities necessary to access services for their clients. For example, one counselor mentioned, "Case management. There's no time for it, and we don't get paid for it, but we're expected to do it" (Site 2). Another counselor reported,

> "I would say that I still put in the time into case management that is needed because that's the focus…but then other areas have to suffer. And usually that means that we don't eat lunch…or we stay later and that kind of thing. But the case management piece is just really important, and we make it important" (Site 4).

Directors also noted barriers to providing case management for clients in their programs. One director remarked, "…I think sometimes for the general drug and alcohol counselor who has a high caseload who's doing family work, to do all case management is too much to put on them, and it's not realistic. And that's what's being put on them" (Site 14). Another director expressed a similar sentiment, by stating very plainly, "There's no time for case management" (Site 15). A director from another site added, "And case management services like that is not something billable…and if we can't bill it, we can't spend time on it" (Site 8). In fact, a desire to hire someone to do case management was expressed by counselors and directors at five different sites (2 Project A and 3 Project B). As one counselor put it, "…we daydream about case managers, and we feel it would be reasonable to have a least a part-time person" (Site 5). In sum, counselors and directors at nearly all of the sites

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expressed that counselors were expected to provide case management services to their clients, some even expressing that this was important and rewarding. However, many talked about barriers to actually providing this care, which left some of them wishing for a specialized staff member to take on this responsibility.

Individualized care requires an environment that fosters individual attention to clients and their needs as well as an environment that supports counselors in providing this type of care. In talking with counselors and directors participating in the CASPAR studies we found that individual sessions for clients were relatively rare, counselors had infrequent or irregular individual supervision, and there was little time for them to under-take case management activities.

Discussion and Conclusions

It is important to acknowledge that this study provides only a snapshot of substance abuse treatment in 16 treatment sites in two states. Further, because we did not require all counselors from each site to participate in the CASPAR studies, we cannot say that our findings represent all counselors or how treatment is delivered among all counselors at the participating sites. However, our findings have implications for the substance abuse treatment field and for substance abuse researchers as well.

The CASPAR Resource Guide was developed to enhance matching of client needs to services (on-site or via referral) within the context or philosophy of patient-centered care, ideally being used to provide service referrals to clients during an individual treatment planning session shortly after these needs are identified with a multi-dimensional intake assessment. During interviews and focus groups with counselors and directors participating in the CASPAR replications studies, we discovered a number of barriers to using the CASPAR Resource Guide in our treatment sites. Namely, we discovered that there was often little linkage between assessment and treatment plan development. We also heard from counselors and directors that they felt limited with respect to what they could do with the treatment plan and, as a result, saw little value in it. More importantly, we also discovered a lack of infrastructure to support individualized care; individual sessions with clients were the exception rather than the rule, counselors rarely participated in structured, individual supervision, and counselors rarely felt that they had time to engage in case management activities regardless of how important and necessary they agreed these activities were.

The CASPAR replication projects represent attempts to transport or implement an evidence-based practice (EBP) into 16 different community-based outpatient treatment programs. In recent years, the push for community-based treatment programs to provide EBPs, or empirically supported treatment has increased; however, there are substantial barriers to implementing treatments proven to be effective in academic clinical settings to community-based programs (Massatti et al., 2008). Our investigation of the lack of use of the CASPAR Resource Guide in two large-scale replication studies revealed much about the "systems-requirements" for programs to get maximum benefit from it. Namely, its use and effectiveness is limited by the extent to which substance abuse programs can deliver patient-centered care through individualized treatment planning, referral to off-site services, linkage to off-site services and provide counselors with the time, supervision, and encouragement needed to deliver such care. Our study also underscores the importance of examining issues that may foster or inhibit implementation as part of the process of transporting EBPs to practice (Liddle et al., 2002).

To address the issues identified in these analyses, we have redesigned the CASPAR projects to be implemented as site-wide quality improvement initiatives with only those sites

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committed to providing individualized treatment planning sessions and individual counseling sessions with clients on at least a monthly basis eligible to participate. With these changes, we are hoping to strengthen the fit between the project and the values of the sites implementing the projects (Klein & Sorra) and to increase institutional and personal readiness to adopt the intervention (Simpson, 2002). We will complete data collection on the redesigned project in 2010, and will be presenting our findings shortly thereafter.

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Table 1

CASPAR Replication Project Characteristics

	Project A	**Project B**
Funding source	NIDA	NIAAA
Location	Philadelphia suburbs	New Jersey (within a 50 mile radius of Atlantic City)
Target population	Clients entering susbtance abuse treatment	Alcohol-dependent clients entering substance abuse treatment
Design elements	Baseline assessment and follow-ups at 2 weeks, 4 weeks, 8 weeks, 12 weeks, and 6 months with clients in both conditions (Pre-CASPAR training)	
	Random assignment to CASPAR intervention or treatment as usual with baseline assessment and follow-ups at 2 weeks, 4 weeks, 8 weeks, 12 weeks, and 6 months with clients in both conditions (Post-CASPAR training)	Random assignment to CASPAR intervention or treatment as usual with baseline assessment and follow-ups at 2 weeks, 4 weeks, 8 weeks, 12 weeks, and 6 months with clients in both conditions
Key outcome measures	Problem to treatment plan matching Service use	Problem to treatment plan matching Service use
	Problem to services received matching	Problem to services received matching
	Treatment retention	Treatment retention
	Treatment outcomes	Treatment outcomes
Additional measures	CASPAR Resource Guide usage logs	CASPAR Resource Guide usage logs
	Biological markers of substance abuse at 6 months	Biological markers of substance abuse at 12 weeks and 6 months
	Helping alliance	
Project start date	Fall 2005	Fall 2006
Sites participating	10 (4 experimental, 4 control, and 2 yet to be assigned--still in Pre-CASPAR training phase)	8 (3 experimental, 5 control)
Counselors enrolled	32	35

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Table 2

CASPAR Qualitative Implementation Analysis Participants

	Organization Status	Primary Funding Source*	Total Capacity	Acreditation**	Counselors Interviewed	Directors Interviewed
Project A						
Site 1	Non-profit, Private	State	270	None	2	1
Site 2	Non-profit, Private	State	300	None	2	1
Site 3	Non-profit, Private	Private insurance	102	State, JCAHO	1	1
Site 4	Non-profit, Private	Private insurance	100	JCAHO	2	1
Site 5	Non-profit, Private	Private insurance	140	JCAHO	1	2
Site 6	For-profit, Private	Private insurance	180	State	3	1
Site 7	For-profit, Private	Private insurance	106	None	2	0***
Site 8	Non-profit, Public	State, Public managed care	270	CARF	1	1
				Total	14	8
Project B						
Site 9	Non-profit, Private	Self-pay	85	State	1	2
Site 10	Non-profit	State	40	None	2	2
Site 11	Non-profit	State	320	None	2	1
Site 12	Non-profit	State	275	JCAHO	5	2
Site 13	Non-profit	State	60	None	1	1
Site 14	Non-profit	Self-pay, State	48	JCAHO, State	2	1
Site 15	Non-profit	State	99	None	1	3
Site 16	Non-profit	State	40	None	2	1
				Total	16	13

NOTE: Program characteristics were collected as part of the replication projects with using the Addiction Treatment Inventory (ATI; Carise et al., 2000)

*Programs were asked about the percent of their funding that came from different sources; primary funding source is defined as the source (or sources) comprising the majority of funding (>50%).

**State accreditation for Project A sites were granted from the Pennsylvania Bureau of Drug & Alcohol Programs (BDAP); State accreditation for Project B sites were granted from the New Jersey Division of Addiction Services (DAS).

***Sites 6 and 7 in Project A had the same director.