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A Community-Engaged Research Approach to the Development of an Assessment Tool for Historical Data Collection of SAARA Client Population

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A thesis submitted in partial fulfillment of the requirements for the degree of Master of Public Health at Virginia Commonwealth University.

by

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Abstract

Through collaboration between the Substance Abuse and Addiction Recovery Alliance (SAARA) and several community partners, a need was identified for a new measurement tool to gather comprehensive client histories for program evaluation and development. The purpose of this study was to (1) develop a culturally relevant and organizationally appropriate mechanism for the collection of comprehensive client histories and (2) to provide the opportunity for staff to engage in a new process of developing and implementing data collection strategies. As a result of the use of a community-based participatory approach, (1) a missed opportunity for program evaluation and development was identified, (2) a community-based research study was developed, (3) staff were invested in development of the tool, and (4) staff engaged in a capacity-building exercise in which they were provided the skills and tools needed to replicate this process independently in the future.

Introduction

The goals of substance abuse treatment include strengthening personal resources, helping clients develop health and economic well-being and life satisfaction (Laudet, Stanick, & Sands, 2009), reducing the frequency and intensity of substance abuse following treatment (McKay & Weiss, 2001), and strengthening the support provided by family and friends (Moos & Moos, 2007). Yet numerous studies have found that treatment effects diminish over time. This is attributed to multiple factors: longer participation in treatment is associated with better substance use outcomes (Hawkins, Baer, & Kivlahan, 2007; McKay & Weiss, 2001; Zang, Friedmann, & Gerstein, 2003), as is a focus on protective resources as opposed to the reduction or elimination of substance use (Moos & Moos, 2007). More recently, the type of treatment received has also become a predictor of the success of recovery from substance abuse and addiction as the range of services available to individuals has expanded.

Peer-Based Recovery Support Services

Research has shown that there are multiple pathways to recovery in the addictions arena. Not all of these pathways involve professionally-directed addiction treatment. Among the alternatives, peer-based recovery support services have gained increasing momentum in recent years. Here, "peer" can be used interchangeably with "consumer" and indicates individuals who are in recovery. Peer support is "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (Mead, Hilton, & Curtis, 2001, p. 135). Peer support exists in the form of self-help groups, peer delivered services, peer run or operated services, peer partnerships, peer employees, and Internet support groups (Solomon, 2004) and includes an array of services and interventions. The

Substance Abuse and Addiction Recovery Alliance (SAARA) is an example of these peer-based services.

Substance Abuse and Addiction Recovery Alliance (SAARA)

The Substance Abuse and Addiction Recovery Alliance (SAARA) evolved in 1996 as a community-based grassroots membership organization of individuals in recovery from alcohol and other drug addiction, their families, friends and committed community supporters (www.saaracenter.org). The organization advocates for and promotes social, educational, legal, research and health care resources and services for prevention, intervention, treatment, and recovery services (www.saaracenter.org). SAARA provides peer-based recovery support services to individuals in different stages of recovery.

SAARA developed out of an identified need in the community and in response to research suggesting that treatment efforts focused on protective resources may have a greater influence on long-term remission than a focus on reducing or eliminating substance abuse (Moos & Moos, 2007), that mutual aid groups and chronic care approaches, including self-management, family supports, and integrated services, produce positive outcomes (Fiorentine & Hillhouse, 2000; Lorig et al., 2001), and that recovery coaches and social and community supports increase the likelihood of achieving long-term recovery (Jason, Davis, Ferrari &Bishop, 2001).

The program is run by certified recovery coaches with a personal history of substance abuse and addiction. These individuals bring a broad range of experiences and diverse backgrounds to the program. What they share in common are their success stories of overcoming addiction and their desire to use these experiences to help others in need. The services that these individuals provide and the experiences that their clients receive are unique

from traditional treatment programs in many ways, though these differences are reported anecdotally and are not founded in research, to date:

> … she relaxed. And I think that's a reflection of the atmosphere here … sometimes people will just come in and spend the day here. They're not here to meet with us. This one lady came in with her laptop intending to work for an hour or two. She ended up staying all day. When she realized how late it was she looked around and said "I like it here. It's peaceful. For her, our ability just to provide her with a quiet space to work away from her kids and hectic household was a service in itself."
>
> …Working here, this helps me in *my* recovery. I think SAARA helps me retain my sanity.
>
> …That's why we talk to them. We *exchange* information. They can relate to us. And they don't get nervous by the moving of the hand as we write down everything they say.

Development of Research Topic

As an employee of Richmond Behavioral Health Authority (RBHA), which provides mental health, mental retardation, substance abuse and prevention services to the citizens of the City of Richmond, I had the unique opportunity to become familiar with SAARA and participate in ongoing organizational meetings with SAARA staff, RBHA staff, jail representatives, Virginia Commonwealth University representatives, and other community partners. Through these meetings, several themes emerged that prompted more in-depth discussion.

Theme 1

The first theme that was explored stemmed from a discussion about producing an annual report for SAARA to increase community awareness of the program and elicit support for continued and expanded services as well as increase the population served. When I asked staff what research existed comparing the effectiveness of peer-based recovery support services to more traditional treatment programs, I was told evidence was entirely anecdotal. I approached the RBHA Substance Abuse Division Director and staff, who reiterated that no research existed on the success nor shortcomings of peer-based recovery services. An internet-based literature review further supported these claims. There are no easily accessible data comparing the effectiveness of peer-based recovery services to more traditional and long-established treatment

programs (medical, psychosocial, faith-based, etc.). Such research would help establish peer-based recovery programs as valid treatment programs, draw funding for continued provision and expanded availability of services, and encourage professionals to consider these programs when linking their clients to community resources.

Theme 2

The second theme that was explored regarded the difficulty in accessing data from Richmond service agencies such as the jails. Accessibility to jail data was relevant to SAARA staff because the agency is in the process of partnering with a jail program that provides social skills training, employment preparation, but limited substance abuse services to the re-entry population. During this discussion, the process and content of SAARA's own data collection procedures was addressed. Although SAARA currently assesses clients at intake using the GPRA Client Outcome Measures and the Self-Sufficiency Matrix questionnaires, there are limitations to the data gathered by these tools. Furthermore, although a rich and in-depth understanding of these clients' lives is obtained by the peer-recovery coaches over the course of their work with the individuals, these data are not recorded in any manner and thus cannot be utilized for research purposes.

<u>GRPA Client Outcome Measures:</u> Currently SAARA uses the CSAT GPRA Client Outcome Measures for Discretionary Programs to collect client data at intake, 3-month follow-up, 6-month follow-up and at discharge. The GPRA tool gathers basic demographic data on age, gender, race, and ethnicity. A series of questions are then asked about the client's drug use, employment status, services received, social support, and legal issues **during the past 30 days**. This data provides some insight into the reasons for which the client sought SAARA services but is of little

use in predicting client outcomes or determining which populations SAARA services are reaching.

Furthermore, GPRA does not gather data on receipt of prior services, length of stay of prior treatments, past readmission rates, or length and frequency of periods of abstinence. These measures are valuable in the substance abuse arena to monitor and evaluate the quality of care provided. In this context, these data could be useful to help predict long-term outcomes and assess client progress at SAARA and to compare the success of SAARA's peer-based services to traditional professional services (Dausey, Pincus, & Herrell, 2009).

Self-Sufficiency Matrix: The Self-Sufficiency Matrix is also administered at intake and clients are asked to rate themselves in a series of domains in terms of where they are now and where they would like to be in three and six months. Domains include recovery, housing, employment, legal, emotional well-being, support, and transportation. This tool provides information on the client's readiness to change and provides preliminary goals from which to work, but without any historical data on the clients, it is impossible to determine why client responses differ on 3-month goals or why success in achieving these goals varies among clients. Are certain types of individuals more likely to set higher 3-month goals for themselves than others in certain domains or across all domains?

An Emerging Research Opportunity

As these themes were addressed in greater depth, discussion emerged about the need for a new measurement tool to gather more comprehensive client histories. Obtaining this data would allow for assessment of the clients served by SAARA. The limitations of the current tools make it difficult to 1) understand needs and experiences of clients occurring before that 30-day time period, 2) determine whether SAARA is reaching its target population, 3) determine which

individuals benefit most from the services provided, and 4) determine what clients the center may be missing.

Clients in Treatment

Observations by SAARA staff suggest a higher client retention rate at SAARA than most treatment programs. Staff approximate that their retention rate is 85%, but this statistic is difficult to measure based on the range of services provided. In addition, as of January 2010, clients reported consistent increases over time in self-sufficiency in each of seven dimensions, further suggesting effectiveness of the program. Despite the power limitations imposed by the relatively small sample for whom data were available, self-rated changes were statistically significant for all seven variables measured: recovery ($F= 18.78$, $p<.0001$), housing ($F=7.49$, $p<.001$), employment ($F=5.72$, $p<.01$) emotional well-being ($F=22.62$, $p<.0001$), social support ($F=11.75$, $p<.0001$), transportation ($F=5.97$, $p<.01$), and legal ($F=3.94$,$p<.03$) ($df=2,54$) (Substance Abuse and Addiction Recovery Alliance (SAARA), 2010). These statistics suggest that SAARA has been successful thus far in maintaining client satisfaction with the program and providing clients the tools needed to begin the recovery process. However, this data is only available for individuals who continue to receive SAARA services and are available for follow-up. It would be helpful to identify what characterizes individuals who stay compared to those who do not, what characterizes individuals who benefit the most from SAARA services, to explore whether individuals seeking SAARA services have similar or varying backgrounds at time of intake, and to determine why they were unsuccessful in other treatment programs to ensure that they obtain the most appropriate services for their specific needs at SAARA.

Publicly funded programs maintain a completion rate of only 36% in outpatient settings and average 44% across other modalities (SAMSHA Treatment Episode Data Set 2005, 2008).

One study done by Laudet, Stanick, and Sands (2003) found that client reasons for leaving treatment early included dislike of the program (31.8%), dislike of the staff (13.7%), program interference with other scheduled activities (18.8%), relapse (13.7%), personal issues such as family, physical health, or other (11.9%), and feeling the program was not helpful (8.5%). Identifying which of these issues are relevant to SAARA clients during their previous treatment experiences would help the organization tailor its own program to better meet the needs of these individuals.

Furthermore, research has suggested that certain populations are more likely to receive services than others. The National Survey on Drug Use and Health reports that among those in need of treatment for substance abuse and addiction, African Americans have a higher rate of treatment receipt than Hispanics, whites, and Asians (17.8 vs. 11.3, 9.2, and 5.5, respectively). It would benefit SAARA to identify which populations are seeking and utilizing the agency's services. There is reason to believe that there are differences in the types of clients, treatments, and environmental factors that influence adherence to treatment programs as well as short- and long-term outcomes (McKay & Weiss, 2001). Are SAARA services available to, targeting, or sought by the same populations as other treatment modalities or by those individuals who do not have access to or have not benefited from other treatment programs? Are SAARA peer-services more attractive to individuals who have a serious and long history of addiction or individuals who have experienced more recent addiction? Are the services offered more attractive to individuals whose lives are fairly stable at the time or to those who are threatened by homelessness, unemployment, and rejection from family and friends? When one staff member was asked if, in his opinion, they provided services to the same population currently served by

other treatment programs or if he believed SAARA was reaching a missed population, he responded:

> …I think we're the crack pluggers. We fill all those holes left by other agencies through which some individuals fall.

Theory-Driven Assessment

As mentioned previously, the GPRA assesses clients on a range of factors, including personal factors, social factors, and socioeconomic factors. This reflects the Socio-Ecological model of human behavior (see Figure 1), which posits that behavior is determined by a constant and reciprocal interaction between multiple factors and that in order to understand a person's behavior one must observe and assess the multiple facets of their environment (Edberg, 2007). However, one of the most difficult challenges for professionals in the human services field "is to develop a broad, multidimensional approach to human behavior without unacceptable sacrifice of depth" (Hutchison, 2008).

At this point I would like to revisit the previous discussion of the GPRA tool. Although it assesses clients on a range of individual and environmental factors, it does so within the context of the "past 30 days". This provides a very narrow scope through which to explore and attempt to understand client histories and experiences. Furthermore, a client's last 30 days prior to seeking services at SAARA may present a dramatically different experience than their past six months or past two years. Some change in the past 30 days may be the reason for which they elected to contact SAARA and appeal for help in their recovery. One staff member even suggested that asking an individual only about the past 30 days in reference to drug use and abstinence may have a negative effect on them:

> …It's discouraging to only ask about the past 30 days because people are very proud of their 'clean time'. They may have been clean for 6 months but slipped right before they came to SAARA.

As a result of these identified shortcomings, staff and community partners began discussion of the need for a new measurement tool to gather comprehensive client histories. To help understand the limitations of the GPRA data in the context of the bigger picture, I have modified the Socio-Ecological Model and added a time dimension which identifies the extent of current data collected and the potential data to be accessed with the incorporation of a new tool (see Figure 2).

Study Purpose

The purpose of this study is two-fold. First, we seek to develop a culturally relevant and organizationally appropriate mechanism for the collection of comprehensive client histories. Second, we seek to provide the opportunity for staff to engage in a new process of developing and implementing data collection strategies. Although implementation of the tool by SAARA is not within the scope of this study, it is anticipated that at the conclusion of this study SAARA staff will have the skills needed to (1) see the development of the tool through to completion and (2) replicate the process of tool development independently when a future need arises.

Methods

A qualitative study design was used to develop a mechanism for the collection of historical data from the SAARA client population. This study design was selected because, although qualitative methods are more labor intensive, the results are typically of greater value because the information collected is of the individual's personal experience, described in his or her own words (Cozby, 2004). The design included a **pre-research phase** and a **study phase**. A **community-based participatory approach (CBPR)** was used throughout (see Figure 3).

Pre-Research Phase

One of the many unique factors in this study was the identification of an organization need and discussion of the process of addressing this need prior to development of the study. These discussions informed the research. This early collaboration between SAARA staff, the research team, and other community partners ensured that the need was community-based rather than community-placed, one of the key tenets of CBPR. Furthermore, it laid the groundwork for the community-based participatory approach pervasive throughout the study process.

As the research study idea was developed, the research staff began to review meeting notes and identified several general themes that had been brought up in meetings: treatment history, legal history, home-ownership history, transportation history, employment history, substance abuse history, and family history. These themes were taken back to the team in subsequent meetings and specific questions were brainstormed and recorded.

Study Phase

Once the goals of the team were clear, the study objective was established. VCU IRB approval was obtained for research with human subjects. A measurement tool for historical data collection of SAARA clients was developed by the research team using the notes and discussions from SAARA organizational meetings (Appendix B). A comparison of sample questions from the new tool and questions from the currently used GPRA can be found in Table 1. Questions were then submitted through the Question Understanding Aid (QUAID) to analyze question wording. QUAID is a computer program that identifies problems related to vague or imprecise terms, unfamiliar terms, vague or ambiguous phrases, complex syntax, and working memory overload. Critiques provided by the program were reviewed and recorded to be revisited later.

The questionnaire was then field-tested on a small sample of individuals. Purposive sampling was determined to be appropriate in this study because of the data sought after. Patton (2002) explains:

> What would be "bias" in statistical sampling, and therefore a weakness, becomes the intended focus in qualitative sampling, and therefore a strength. […] Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposive sampling (or alternatively, purposeful sampling). Studying information-rich cases yields insights and in-depth understanding rather than empirical generalizations.

In this study, the SAARA staff were selected as study participants because of the common histories they share with SAARA clients and because of their one-on-one relationships and more in-depth understanding of the clients with whom they work. Participants were given the questionnaire and asked to review it and jot down the answers it prompted from them along with any thoughts, suggestions, or critiques of the questionnaire.

Immediately following completion of the questionnaire, each respondent participated in a follow-up interview with the researcher regarding interpretation and appropriateness of the questions asked. A non-directive approach was used to gauge prominent issues to participants, supplemented by a semi-structured interview format to ensure an in-depth discussion of the instrument. Table 2 contains examples of questions asked during the semi-structured interview. If a question was already addressed during the open discussion with the participant, it was not asked again during the semi-structured component. Each interview, including both the questionnaire and follow-up interview, was between 30 minutes and 60 minutes in duration.

The study entailed an iterative process of revisiting old discussions about program needs and shortcomings and exploring possible solutions. There were multiple "checkpoints" in which research staff contacted SAARA staff to discuss new developments and obtain feedback. Another unique element of this study was the fact that participants in the study were also partners

in the study design and process. SAARA staff were an integral part of each step in the research study (see Figure 3), once again reiterating the community based participatory approach used.

Community Based Participatory Approach

As mentioned earlier, research can be identified either as "community placed" or "community based". The distinguishing factor between these two types of research is who is regarded as an expert. In community placed research, the research is driven by an outside expert, an academic, a professional researcher. Conversely, in community based research, those individuals invested in or affected by an issue are considered experts with unique strengths and perspectives. Community-based participatory research is a newly emerging research paradigm in which the lay person is just as vital to the research as the professional. Through this approach, a research topic or question is produced by the local community in response to an identified need. Engaging academic researchers, professionals, and community leaders and representatives equitably ensures that the issue really is relevant to the population of interest. This collaborative process often continues for the duration of the research to provide multiple perspectives in the interpretation and dissemination of results. Such partnership structures are particularly valuable in survey research in "[improving] measurement instruments by making sure that questions are worded in ways that will elicit valid and reliable responses" (Minkler, 2005, p.ii6).

Findings

Analysis of participant responses identified four major themes: Vocabulary and Structure of Questions, Content, Feasibility and Logistics, and Purpose, Although an "outside expert" may have identified similar themes to discuss, the staff provided unique insight about their clients that would not have been obtained if the researcher had conducted the study independently.

Vocabulary and Structure of Questions

Several terms were identified as being subjective and relative to the experiences of the individuals participating in the interview. Terms such as *treatment* and *structured treatment plan* were identified by participants as needing clarification. Individuals may have different understandings of what constitutes treatment. Other terms, such as *addicted* and *abuse*, were identified as having the potential to skew responses because some individuals receiving SAARA services may not believe they are addicted or abusing alcohol or drugs. For example, one participant stated:

> …you'll get someone in here who is faith-based who will say "I'm not addicted, I'm just deep in sin" and they'll believe it, they'll really mean it.

Similarly, one participant suggested that the question "Have you ever lost a job because of substance abuse?" may be interpreted differently by various individuals. This participant stated:

> …you may have a guy who says "No, I didn't lose my job because of substance use. I lost my job because I was stealing." It doesn't matter that he was stealing money so that he could buy drugs.

Content

Participants found the content of the questionnaire to be appropriate and thorough. One participant suggested the addition of a section on spirituality, which the participant indicated was an often overlooked resource and protective factor for an individual in treatment or recovery. Another participant suggested the inclusion of a question identifying veterans so that, should funds or programs become available or be sought out specifically for this population, the research can be used to explore relevant histories, unique characteristics, and appropriateness of SAARA services.

Participants did not find questions to be superfluous and found the tool to be supplemental to those measurement tools currently in use at SAARA. Furthermore, none of the participants identified any questions that they believed would impose a greater-than-normal amount of stress or discomfort to participants.

Feasibility and Logistics of Administering Questionnaire

This theme presented some conflicting opinions among participants. One participant was adamant that participants would not be willing to answer personal questions before developing a relationship with their peer counselor.

> …I'm not sure I'd wanna answer this thing right here … it'd be easier for me to answer now…but in the beginning? I was off the chain!

However, the remaining four participants did not foresee any difficulties obtaining responses to all questions.

There was also discussion about the most appropriate time to administer the questionnaire. The primary purpose of the tool, at this time, is to gather data on clients about their experiences before SAARA to compare effectiveness of traditional treatment programs to peer recovery. Therefore, there is concern that administering the questionnaire after clients have received SAARA services for several months may make it difficult to distinguish outcomes of traditional treatment programs from outcomes resulting from the receipt of SAARA services. All five participants recommended that the questionnaire could be administered with success and without resistance between an individual's 3rd and 5th visit to the center.

Purpose

Two potential uses of the questionnaire were identified: (1) to inform research and/or (2) to provide recovery coaches with a multidimensional assessment of their clients at intake to help them determine the services and resources most suitable to each individual. While three of the

participants believed this tool would best be used for the purposes of research and did not feel it would benefit them personally, the other two participants were very excited about the prospect of obtaining all this data simultaneously and up front. One participant explained that, although all of this information is eventually obtained, it often has to be pieced together and it is more difficult to see the big picture. Conversely, another participant stated:

> …We'll typically piece-meal it out and address these questions a little bit here and a little bit there. Not have to do all this before we get started.

Another factor that must be considered here is the issue of anonymity. If the questionnaire is used strictly to inform research, there is no need to attach identifiable information to the responses. However, if the questionnaire is meant to serve as an assessment tool to SAARA staff, it would be necessary to identify the participant.

Discussion

One of the distinguishing factors of qualitative research is that the study usually does not have an expected outcome and, as a result, the research guides the study (Patton, 2002). The initial focus of this study was on the actual tool and its development and revision. However, during the process of eliciting staff feedback about the tool, observations by the research team identified a more pertinent issue. It was observed that there were opportunities for capacity-building within the agency and that providing the staff the means by which to develop tools would have the greatest and most lasting impact.

Although staff provided valuable input regarding revisions of the new measurement tool, the emphasis of this study was redirected towards the process through which they did so. Staff were engaged in the study process as key informants, partners in development, and as study participants. The CBPR approach used in the study design was critical in achieving the objectives sought. By involving community partners in the research, (1) a missed opportunity

for program evaluation and planning was identified which led to development of the research study, (2) a community-based research study was developed, (3) staff were invested in development of the tool, and (4) staff engaged in a capacity-building exercise in which they were provided the skills and tools needed to replicate this process independently in the future.

A missed opportunity for program evaluation and development was identified. Discussion with SAARA staff and other community partners identified limitations of data collection and analysis for the purpose of grant deliverables. GPRA data is collected at intake as a requirement of the grant. However, a comprehensive assessment is not conducted and therefore baseline data is limited to client self-reports of recovery, housing, employment, emotional well-being, social support, and legal matters, which are measured using scaled responses in the Self-Sufficiency Matrix. Because responses are not open-ended, individual's unique experiences are not recorded. As Patton (1987) succinctly explains:

> It makes sense to count the number of people who enter a program, the number who leave the program, and the number who receive or report some concrete benefit from the program. There are many attributes of programs, however, that do not lend themselves to counting. Even the scaling of quality attributes is an inadequate way of capturing either program quality or the effect of a program on the quality of life experienced by participants following the program. The answers to these questions require description of the individual's perspective such that the meaning of the experience for the individual is recorded. (p.29)

While recovery coaches obtain this information through their work with individuals, the data is not recorded and therefore of no use in evaluating program effectiveness. These discussions during regular agency meetings identified a community-based need for a mechanism by which to evaluate the SAARA program.

A community-based research study was developed. As a result of these identified gaps in data collection and agency needs, discussion of an opportunity to develop a new tool ensued. The collaborative process evident in staff meetings was carried through study development and

incorporated into the study design because of recognition of the valuable insight and vested interest of those involved.

Staff were invested in development of the tool. It was extremely important that staff bought into the idea of developing and incorporating this tool into current SAARA procedures. Patton (1987) cites "the challenge in evaluation is getting the best possible information to the people who need it – and then getting those people to actually use the information in decision making" (p.9). Not only will staff have to be the ones to administer the questionnaire and master this process, but they must be able to authentically explain its significance to any clients who are skeptical about participating. Because staff recognized the need for and benefits of this tool and were involved in its planning and development, they are excited about its implementation and this excitement is apparent when they talk about it. Had a research team or community agency approached SAARA with a new measurement tool and demanded implementation, staff may not have been as receptive. Said one SAARA staff member:

> …If this staff is expected to use the instrument, then their input is absolutely vital. Further, it must always be remembered that the primary job qualification for employees (and volunteers) here is their EXPERIENCE, Strength & Hope in Recovery. For us, while we value, welcome & need input from many sources, to simply dictate the process to us is to deny us our core motivation and invalidate our personal stories....

Staff engaged in a capacity-building exercise. The research team designed the follow-up interview procedures in such a way as to not guide the initial discussion. We were interested in observing the most important themes brought up by participants. However, there was not as much participant-guided discussion as expected. Participants required prompting for most of the interview. The issues that participants did address independently were limited to vocabulary and question wording. As several of them do not have any college or post-college education, it occurred to me that this may have been the first time they were asked to critically analyze a

document and take on the role of a researcher. There is no question that they excel in their roles as certified recovery coaches:

> I really do believe that the staff here has worked very hard to develop something very unique and special....They are VERY good at what they do and their experience & knowledge are invaluable. However, I am ALWAYS surprised that ANYONE actually wants me to discuss my opinions.

However, "durable programs must have, or develop, traits that prepare them for inevitable change, especially for adopting appropriate technologies to meet evolving demands." (Simpson, 2002). Staff have had limited opportunities to engage in research or practice opportunities where they are treated as experts outside of this setting. This highlighted an opportunity for capacity-building among these individuals and within the agency setting to enable them to take on more roles in the future. Continued training and education opportunities should be sought and taken advantage of to continue capacity-building.

Through their participation in the process of tool development in this study, staff were provided a mechanism with which to develop future data collection tools as the need arises.

> We can never forget that we have an obligation to help replicate this type of organization in other places in the future. In order to do so, we must understand the vital role that research plays in our funding and in helping us (now & in the future) do a better job for our peers and others in the helping professions.

In terms of more short-term goals, the involvement of the staff throughout this study has enabled them to continue developing the tool independently and see it through to implementation.

Strengths and Limitations

The community-based participatory approach used in this study was a significant strength. Not only did it incorporate the expertise of individuals with the greatest awareness and understanding of the population and program, but it reflected the core beliefs and motivation from which SAARA services are inspired. One of the core principles in service delivery at SAARA is *experience*. Recovery coaches have experience from which they draw their skills and

expertise. To reframe that in the context of the questionnaire, their use and delivery of the questionnaire will be more authentic because they experienced the process.

It is important to note, however, that the measurement tool and its process of development were specific to the needs of the SAARA agency and its clients and therefore is not generalizable. Furthermore, there was dissention in opinion regarding perceived client willingness to participate among respondents during the follow-up interviews. These differing opinions will be explored in greater depth during pilot-testing, which is outside the scope of this study.

Next Steps

There are several more recommended steps in tool development before the questionnaire is implemented at SAARA. After revisions are made, staff should meet with community partners again to review changes. Staff also need to be trained to administer the tool and respond appropriately to any questions posed by clients or requests for clarification. Once staff have been trained, pilot-testing can begin with a small sample of SAARA clients to gain further input from another population of "experts".

Key Learnings

This project provided me with a unique and valuable learning opportunity. Qualitative research was, for all intensive purposes, an unfamiliar realm for me. Though I knew the distinguishing factors between qualitative and quantitative research, my ability to apply any real-world skills was limited to the more structured and practiced statistical methods. Through completion of this study, I have gained a deeper understanding of the process of qualitative research and the degree of careful planning and execution required, regardless of the fact that data collection is less constrained by predetermined categories of analysis (Patton, 1987).

One of the major challenges I faced during this process was bridging the gap between academics and practice, between the typical research project and the significant findings I observed in my research. What I found over and over again as I sought advice from the VCU Department website, from colleagues and research assistants at my place of employment, and from peers, was a push towards the typical procedures and results seen on posters and in papers, in other words, towards the familiar. While I believe my peers gained valuable practice in statistical methods and research and are more competent as a result, I think I was given the unique challenge of taking what I know about theory, research, service agencies, and core values of social work and public health and applying my knowledge in a new context.

Specifically, I found myself stuck when I tried to discuss significant results. I felt obliged to report the facts, whereas I felt the most significant findings in my research were my observations about the process. I did not see how it would benefit someone to look at my poster and learn that the words *addiction* and *treatment* were vague or subject to interpretation by clients unless they were going to be involved in revision of the questionnaire. I did, however, find it important to share my observations that staff were very concrete in their critiques of the tool. They critiqued what they were actually able to read on the page, but did not address the circumstances in which the tool would be administered, what obstacles they foresaw in implementation, etc. This signified to me that there was an opportunity for capacity-building in the agency, which is of much greater significance to an individual in the field of public health.

Another valuable and unique learning experience was obtaining IRB approval for my study. Before this project, I had never even seen an IRB submission form before. The process of submitting my study to the IRB required that I think through each step of my design carefully and anticipate any obstacles. I had to consider how I would contact study subjects and invite

them to participate because I had to submit any written materials that I would be providing them. I had to consider how I would ensure anonymity and confidentiality. I had to consider how I would collect data and how it would be handled and protected. I also had to consider how my study may be harmful to study participants. It is important to be objective in this assessment and take into consideration that individuals come from different backgrounds and have different experiences and may be triggered by different things. Exploring ways in which my study may have caused greater-than-minimal discomfort for participants required *starting where the client is* and *demonstrating cultural competence*, which are core values in social work practice (Hepworth, 2006).

Another significant learning experience for me was the opportunity to participate actively in community-engaged research. CBPR is advantageous for many reasons, one of which being its ability to ensure the most streamlined and coordinated provision of services. CBPR reminds me in many ways of case management in social work. One of the biggest problems acknowledged in social work practice is the overlapping of some services while simultaneously overlooking gaps in other services and the lack of communication between multiple professionals providing services to an individual. A case manager's responsibility is to streamline services, ensure that all of the client's needs are being met, act as a liaison between agencies, and keep all involved partners in the care of an individual updated on a client's needs, resources, issues, etc. Otherwise, a client risks being approached by several professionals offering the same services without knowledge of services already being received and not being contacted by other professionals or agencies who have valuable, but untapped resources for the client. Similarly, CBPR ensures that the most valuable knowledge and information is being obtained, that tools and services are not being provided to an individual or community

unnecessarily (community-placed research rather than community-based research), that communication is maintained between all involved community partners, and that all relevant needs are being addressed.

Finally, if I had developed this tool independently and sought input from various individuals, they probably would have addressed issues of vocabulary, sentence structure, sensitivity of the material, means of administering the tool, etc., just as SAARA staff did. I probably would have come out of this project with a better understanding of questionnaire development and would have been able to produce other questionnaires in the future. SAARA staff would have had a new tool to use and somebody down the road, whether within the SAARA staff or an outside evaluator, may have used the data collected to do some research. However, this would have been of very little benefit to SAARA staff and clients. The tool may have been more of a hassle than a perceived improvement. Staff may not have seen it as a tool by which to better their program and improve services to the clients they serve. Most importantly, the staff would not have obtained any new skills to better their own contribution to SAARA and its clients. CBPR addresses many of these potential issues with outside-expert drive research because it " 'involves systems development and local community capacity development,' is 'a co-learning process' to which community members and outside researchers contribute equally, and 'achieves a balance between research and action.' " (Minkler, 2005, p.ii4).

Conclusion

Through the course of this study, SAARA was given several useful tools for program evaluation and development. Not only were staff provided with a new questionnaire to use in research and practice, but they were provided with the skills to develop questionnaires in the

future as the need arises. The study created an evaluation pathway to more effectively evaluate program outcomes and implement changes and, as a result of the participatory approach used, staff bought into the process and acknowledged the significance of critically assessing current status and future directions of the program.

Tables and Figures

Figure 1. Socio-Ecological Model

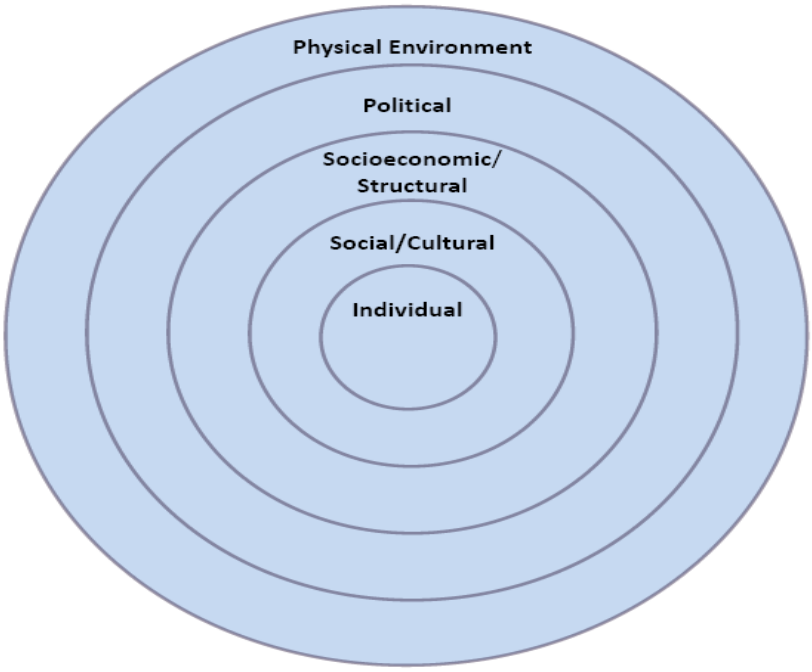

Figure 2. Modified Socio-Ecological Model with Application of Time Dimension

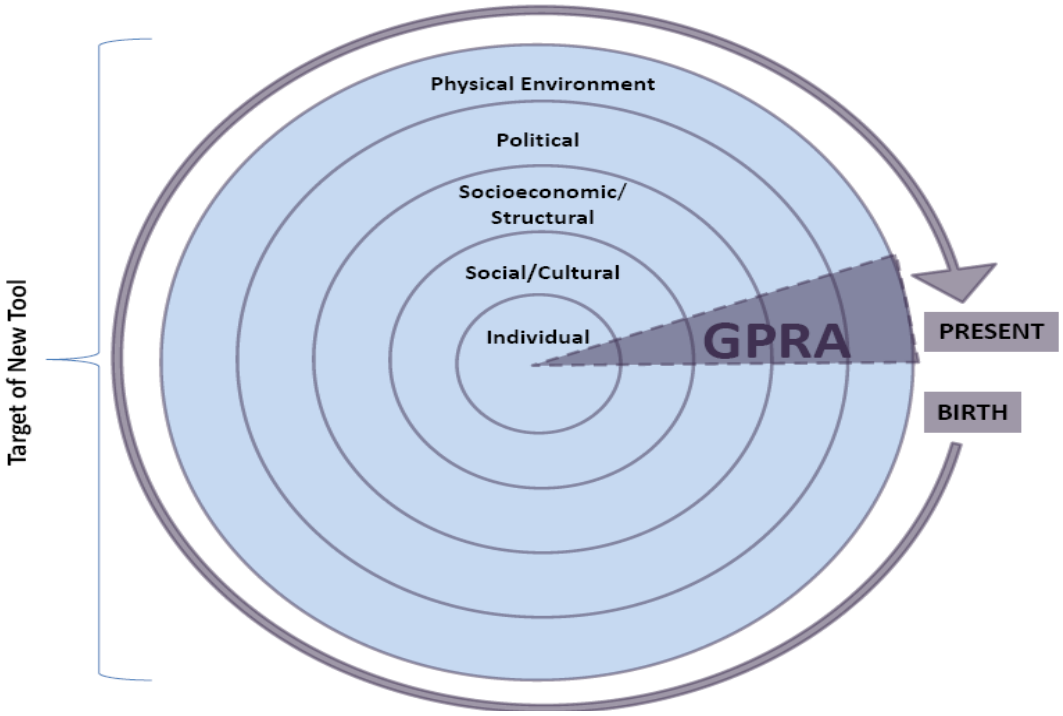

Figure 3. CBPR Process

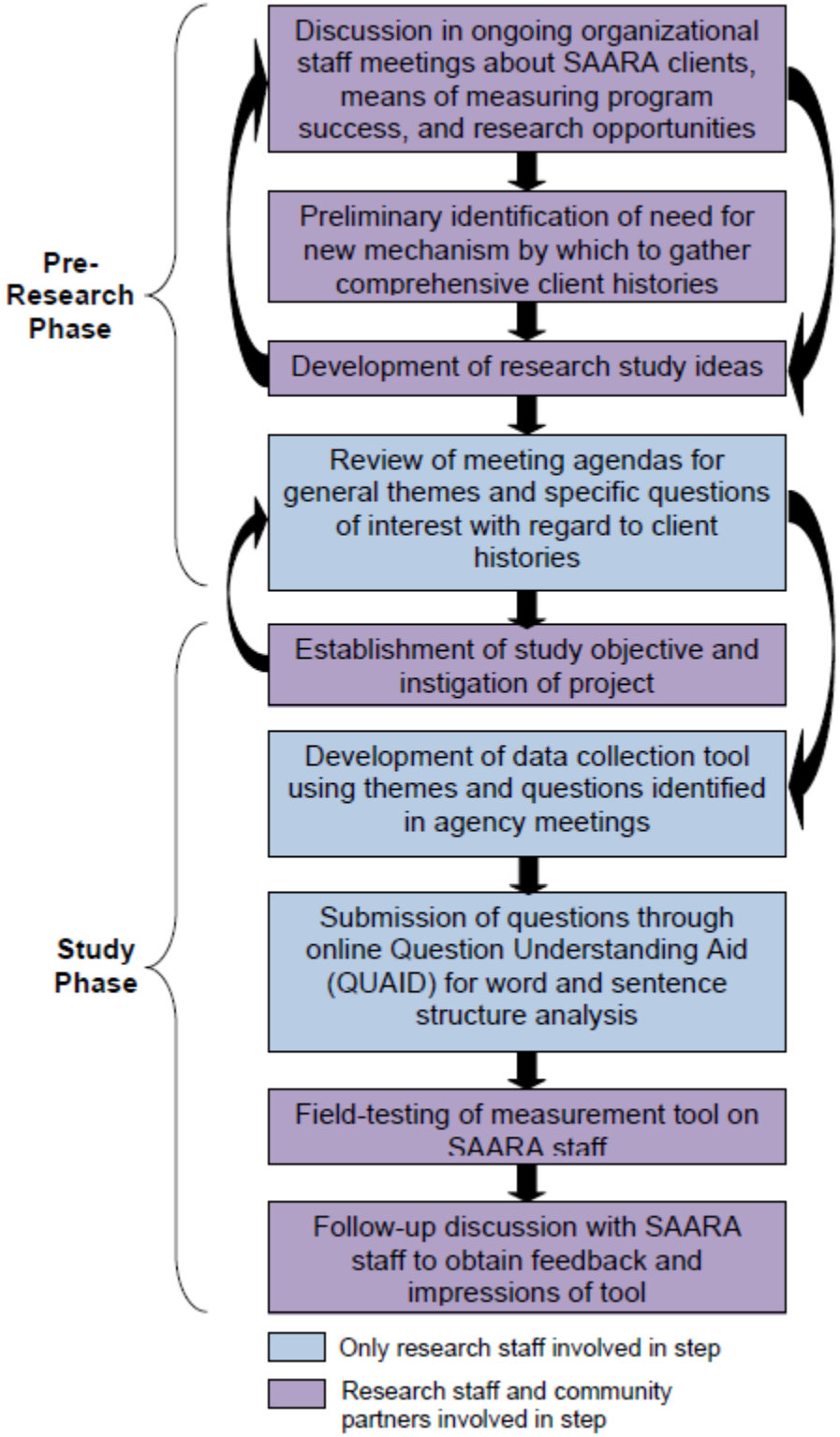

Table 1. Sample Questions from Questionnaire	
Socio-Ecological Model	**Question**
Individual	Old Tool: In the past 30 days, how many days have you used any of the following: alcohol, illegal drugs, alcohol and drugs…?
	New Tool: What is your drug(s) of choice?
Social/Cultural	Old Tool: In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?
	New Tool: When did someone first tell you you were addicted?
Socioeconomic	Old Tool: In the past 30 days, where have you been living most of the time?
	New Tool: Have you ever lived on the street, slept in a car, sofa-crashed, etc.?
Political	Old Tool: During the past 30 days, did you receive: inpatient treatment, outpatient treatment, emergency room treatment…?
	New Tool: If you ever left a treatment program prematurely, what could have been done differently so you would have stayed?
Physical Environment	N/A
	N/A

Table 2. Semi-Structured Follow-Up Interview Questions	
1	Do you think this questionnaire will supplement existing measurement tools or does it seem redundant?
2	What would be the greatest benefit TO YOU in your role here of knowing the information in this questionnaire? How would this help you?
3	What, in your opinion, are the most important themes in this questionnaire?
4	What are the most important questions?
5	Do you think any of these questions would be better assessed using a scale instead of an open-ended format? Which ones?
6	Are there any questions that you believe would cause a higher-than-normal amount of stress or discomfort to the peers?
7	Are any of the questions confusing?
8	Do you think an incentive is necessary to encourage peer participation?
9	Was the answer each question prompted from you information that would be valuable or did some of the questions "get at" the wrong thing?
10	Did anything else really jump out at you or stick with you in your mind that you would want to share now?
11	When, in your opinion, would be the best time to conduct this interview with the peers?

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Appendices

Appendix A. SAARA Brainstorming Session

SAARA Brainstorming Session – January 7, 2010

Qualitative ?: What led to relapse? Stressors? Relationships? Triggers?

1st drink, drug, cigarette,
How long addicted?
History of addiction?
How many Tx episodes before recovery?
Over course of life, when did you first believe you were addicted?
    When did someone else first tell you you were addicted?
Any periods of 30 days or more when you didn't use AT ALL?
    What was the longest period?
    Qualitative ?: HOW did you abstain?
When did you first become involved with criminal justice system?
Risky behaviors?
How did you hear about SAARA?
Look at success of program adjusting for ENVIRONMENTAL FACTORS:
SAARA:
    Transportation?
    Times service is available?
    Location?
    Advertising?
    Were you sought out or self-identified?
Look at success of program adjusting for PERSONAL FACTORS:
    1st use
    Length of addiction
    Family
Previous recovery efforts?
    Ever?
    How long?
    How?
    How/why relapse?
    Why are you here now?
HOW did you hear about us vs. WHY did you come here?
History of use or addiction by parents? Grandparents? Siblings?
Have you ever owned a house?
Have you ever lost a house?
Ever lived on the street?
Ever slept in a car?
Ever sofa-crashed?
Are you homeless?
Ever been in treatment?
Ever had structured treatment plan?
Ever been mandated to do this stuff?
Ever incarcerated in state jail?

Federal prison?
Probation?
Parole?
Drug Treatment Court?
Daily Reporting?
Ever violated probation or parole?

Do you have a valid driver's license?

Have you ever lost your driver's license?

How many times?
Why?

Appendix B. Questionnaire

SAARA Center Questionnaire for Historical Data Collection of SAARA Client Population

Section 1 - SAARA

1.10 When did you first come to SAARA and why?

1.20 About how many times have you returned to SAARA? How frequently?

1.30 Do you see the same staff member during most or all of your visits or do you see a different individual each time?

1.40 What services do you receive from SAARA?

1.50 Are there any services you would like to see SAARA provide that are not currently available to you?

1.60 What do you like most about SAARA?

1.70 What has been the greatest benefit you have received from SAARA?

Section 2 – Treatment History

2.10 Have you ever been in treatment for substance abuse before?

2.20 How many times have you been in substance abuse treatment before?

2.30 Have you ever had a structured treatment plan? If yes, can you please explain the plan to me?

2.40 Have you ever been mandated to treatment? _____

2.41 If yes, when? _____

2.42 How many times have you been mandated to treatment? _____

2.43 Can you please tell me why you were mandated to treatment each of these times?

The following questions are in reference to these previous times in which you received substance abuse treatment:

2.50 Did you complete the treatment program or did you leave the program/treatment prematurely?

2.51 If you left prematurely, why?

2.52 What could have been done differently so you may have stayed longer?

2.60 Were you substance-free when you left either by completing the program or leaving prematurely?

2.70 In what ways is SAARA different from the previous programs you have participated in?

Section 3 – Legal History

3.10 Have you ever been incarcerated in state jail? If yes, explain …

3.20 Have you ever been incarcerated in federal prison? If yes, explain …

3.30 Have you ever violated probation? If yes, explain …

3.31 Have you ever violated parole? If yes, explain …

3.31 Have you ever violated Drug Treatment Court? If yes, explain …

3.32 Have you ever violated Daily Reporting? If yes, explain …

3.40 When did you first become involved with the criminal justice system?

Section 4 – General History

4.10 Have you ever owned a house?

4.11 If yes, when did you first become a home owner?

4.12 If yes, for how long have you been a home owner?

4.20 Have you ever lost a house?

4.21 If yes, please explain the circumstances under which you lost your house?

4.30 Have you ever lived on the street? Explain …

4.31 Have you ever slept in a car? Explain …

4.32 Have you ever sofa-crashed? Explain …

4.33 Have you ever otherwise been homeless? Explain …

Section 5 – Transportation History

5.10 Do you have a valid Drivers License?

5.20 Have you ever had your Drivers License revoked?

5.21 If yes, how many times have you had your license revoked?

5.22 If yes, why?

Section 6 – Employment History

6.10 Have you ever lost a job because of your substance use?

6.11 How many times have you lost a job because of your substance abuse?

6.12 Can you please explain the events that occurred that resulted in you losing your job?

6.13 Were you terminated or did you voluntarily leave your place of employment?

6.14 What was your source of income during your unemployment?

6.20 Do you have a job currently?

If yes:

6.21 How long have you been employed there?

6.22 What is your job title and description?

6.23 What is your annual income?

If no:

6.21 How long have you been unemployed?

6.22 What is the reason for your current unemployment?

6.23 What is your source of income right now?

6.24 Are you actively seeking employment?

Section 7 – Substance Abuse History

7.10 What is your drug(s) of choice?

7.20 Over the course of your life, when did you first believe you were addicted?

7.30 When did someone first tell you you were addicted?

7.31 Who told you?

7.32 Were they supportive or confrontational?

7.33 How did being told by someone else that you were addicted affect you?

7.40 Have there been any periods of 30 days or greater when you didn't use AT ALL?

If yes:

7.41 What was the longest period you abstained?

7.42 When was this longest period of abstinence?

7.43 How did you abstain?

Section 8 – Family History

8.10 Are you married? Single? Co-habiting? Other?

8.20 How many times have you been married?

8.30 If you've ever been divorced or separated, would you attribute it to your substance use?

8.40 What is your family composition? Spouse? Children? Etc.?

8.50 Who do you currently live with?

8.60 How would you describe your relationship with your children?

8.61 How would you describe your relationship with your significant other?

8.62 How would you describe your relationship with your parents?

8.70 Are there any family members who refuse to communicate with you because of your current substance abuse?

If yes:

8.71 Who?

8.72 For how long has there been no communication between you and this individual?

8.80 If you're a parent, have you ever had your parental rights revoked or had a child removed from your care because of your substance use?

If yes:

8.81 How did this affect you?

8.82 Did this change your pattern of use? Increase? Decrease? Seek recovery services?

8.90 Is there a history of substance abuse in your family?

8.91 Is anybody in your family currently using?

8.92 Is anybody in your family currently receiving treatment for substance abuse?