

TIPs Evaluation Project Retrospective Study: Wave 1 and 2¹

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Abstract

The Retrospective Study is the first study of the Treatment Improvement Protocols (TIPs) Evaluation Project sponsored by the Center for Substance Abuse Treatment (CSAT). This study employs a two-wave cross sectional survey that measured substance abuse (SA) treatment professionals' knowledge (i.e., awareness), attitudes, and practices regarding the TIP series and the 28 specific TIPs, which were disseminated at study implementation. The diffusion theory (Rogers, 1995) is used as the conceptual framework for the study. Results indicate that almost half of all treatment professionals are aware of TIPs, that attitudes towards TIPs are positive, yet treatment professionals report difficulty in using TIPs in practice. Results are used to make recommendations to improve the development and dissemination of TIPs.

Keywords: Treatment Improvement Protocols (TIPs); substance abuse; substance abuse treatment; diffusion of innovations theory; diffusion theory; substance abuse treatment providers; evaluation; survey research; best practice guidelines; Total Design Method; mixed mode survey design

1. Introduction

The Retrospective Study is the first major study of the Treatment Improvement Protocol (TIP) Series Evaluation Project sponsored by the Center for Substance Abuse Treatment (CSAT). It was designed to assess the Federal government's efforts at developing and disseminating best practice guidelines for substance abuse (SA) treatment by evaluating the development and dissemination of one of CSAT's best known product lines, the TIP series. Using diffusion theory (Rogers, 1995) as its theoretical framework, the Retrospective Study sought to meet the following three objectives:

- (1) To determine the degree to which TIPs are reaching their intended audience (i.e., the SA treatment field's awareness and knowledge of the TIP series)
- (2) To determine whether TIPs contain information appropriate for use by the target audience (i.e., SA treatment professionals' attitudes toward the TIP series)
- (3) To determine the degree to which readers use TIPs, and the impact of TIPs on the SA treatment field (i.e., how SA treatment professionals use TIPs in practice)

¹The opinions and assertions contained in this article are the private views of the authors and are not to be construed as official or as reflecting the views of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, or the Department of Health and Human Services.

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Findings from the Retrospective Study provide vital information regarding the effectiveness of the TIP series. Study results will facilitate modifications to the current TIPs development and dissemination plan so TIPs can better meet the needs of all treatment professionals. This, in turn, will aid in expanding the availability of effective treatment and recovery services for SA problems.

2. Method

2.1. Study design and procedure

The Retrospective Study employed a two-wave cross sectional survey designed to document the extent to which the TIP program has influenced the SA treatment field through the implementation of best practices. Surveys were mailed to a random sample of 4,200 Facility Directors, Clinical Supervisors, and Program Counselors working in State-recognized treatment programs listed in the National Master Facility Inventory (NMFI). Surveys were also mailed to all 57 Single State Agency (SSA) Directors.² The Wave 1 survey focused on the TIP series in general and on the 28 specific TIPs, which were disseminated by study implementation. The Wave 2 survey focused on a specific TIP selected by the respondents as being most useful to them and on a specific TIP selected by the respondents as being less useful to them than other TIPs.

Data collection employed a mixed mode survey using as its basic method a mailed survey with telephone follow-up. In addition to the mailed survey, respondents for both Wave 1 and Wave 2 were offered the opportunity to respond to the surveys electronically. This mixed mode approach was structured around the Total Design Method (TDM) developed by Dillman (1978, 2000). TDM prescribes virtually all the details involved in conducting mail out surveys, from the size of the stationery to the number and timing of follow-ups. TDM was used to assist in the development of the questionnaire, as well as in the design of the multi-staged effort needed to obtain completed questionnaires from each individual surveyed.

2.2. Data collection instruments

Survey instruments were designed to address each of the research objectives presented above. Separate versions of the questionnaire were created for each of the target audiences (SSA Directors, Facility Directors, Clinical Supervisors, and Program Counselors), so the wording of some questions and response categories could be modified slightly to be most appropriate for each audience. The Wave 1 questionnaire asked respondents to answer questions about their awareness, knowledge, and attitudes toward the TIP series in general. They were also asked to provide information about their awareness, knowledge, and use of each of the 28 specific TIPs that had been published at the time of data collection. Finally, respondents were asked if they

²Single State Agencies oversee all Federally recognized substance abuse treatment programs in a State. Each of the 50 States has its own Single State Agency Director. The other 7 SSA Directors are from Washington, D.C., the U.S. territories that have Single State Agencies (Puerto Rico, Virgin Islands, American Samoa, Guam, and Northern Mariana Islands), and the independent State of the Republic of Palau.

were willing to answer additional questions about a TIP they found particularly useful and a TIP that was less useful to them than other TIPs. If respondents agreed to answer additional questions, they were asked to identify their preferred mode of response for the Wave 2 survey (i.e., hard copy survey or electronic transmission).

Respondents who were aware of the TIP series before the survey, and who agreed to answer questions about specific TIPs, received the Wave 2 questionnaire. In this second survey, respondents specified the TIP they found most useful and evaluated features of the TIP, including its content and presentation. Respondents were also asked whether they shared the useful TIP with others; how they used the most useful TIP, both individually and at an organizational level; and to identify successes and barriers they experienced as a result of using the TIP. In addition to a most useful TIP, respondents also specified a TIP they found less useful than other TIPs, and answered questions about its features and utility as well.

2.3. Sampling procedure

The sampling universe included CSAT's four major target audiences: (1) SSA Directors, and the (2) Facility Directors, (3) Clinical Supervisors, and (4) Program Counselors working in State-recognized treatment facilities listed in the NMFI. Based on an understanding of the composition and characteristics of the four target populations, decisions were made regarding the appropriate sampling procedure. Because there was no efficiency to be gained in sampling SSA Directors (total population of 57), the entire population was contacted. A power analysis determined that samples of approximately 1,300 Facility Directors, 1,300 Clinical Supervisors, and 1,600 Program Counselors were needed to achieve the desired level of precision for the Wave 1 survey. Samples of at least 410 respondents for each of the 3 non-SSA groups were needed to achieve the desired precision in Wave 2. As a result, sampling was accomplished by drawing three successive samples without replacement from the list of State-recognized treatment facilities in the 1997 NMFI.

Specific respondents were chosen by sending an introductory letter along with the survey to the Facility Director of each of the facilities sampled. In one-third of the letters, the Director was asked to complete and return the survey. In another third, the Director was asked to forward the survey to the facility's Clinical Supervisor and to encourage that person to complete and return the survey. In the final third of the letters, the Director was asked to determine which Program Counselor's last name was listed first alphabetically among his/her staff, and to forward the survey to that counselor for completion and return. The Director was also asked to identify the supervisor or counselor by name. This permitted contact with the supervisor or counselor if follow-up was required. The total sample for the Retrospective Study was 4,257 potential respondents.

2.4. Data collection procedure

The data collection procedure was nearly identical for both waves of the survey. The specific steps were organized around a sequence of contacts with the four target audiences.

2.4.1. Conduct mailings

The Retrospective Study was implemented in September 1998. The Wave 1 questionnaire package consisted of the survey and a cover letter from the CSAT Acting Director explaining the purpose of the survey, encouraging a response as soon as possible, assuring confidentiality to the respondent, and offering an “800” number in case any questions arose. Each package contained a pre-paid, pre-addressed return envelope for the respondent to use.

Two weeks after the initial mailing, all respondents were sent a reminder postcard. The card thanked those who had already responded and asked those who had not responded to complete the questionnaire and return it as soon as possible. It also asked those who had lost or misplaced their questionnaire to call the “800” number for a replacement.

Four weeks after the initial mailing, a replacement questionnaire was sent to all those who had not responded. This package contained the same items as the first package with the exception of a new cover letter. The new letter explained that the questionnaire was sent and had not been received and that a replacement was being provided for the convenience of the participant in case the original was lost or misplaced.

2.4.2. Conduct telephone follow-up

Two weeks after sending the replacement questionnaire, telephone contact with all those who had not responded after sending the replacement questionnaire began. A maximum of six attempts to contact nonrespondents were made. Follow-up callers were trained in a protocol designed to aid respondents by answering any questions they had regarding the questionnaire and to encourage the completion of the survey. Once callers made personal contact with an individual, follow-up calls to that individual ceased.

2.5. Response rates

The data collection procedure discussed above resulted in overall response rates of 80.1% and 74.1% for the Wave 1 and Wave 2 questionnaires, respectively. Table 1 displays the response rates for the different respondent groups for the Wave 1 and Wave 2 surveys.

...INSERT: Table 1. Response rates for Wave 1 and Wave 2 questionnaires

3. Wave 1 results

Key dependent measures for the Retrospective Study included respondents’ knowledge, attitudes, and practices regarding the TIP series in general and the 28 specific TIPs published at the time of the survey.

3.1. Knowledge

The first objective of the Retrospective Study was to determine the degree to which TIPs are reaching their target audience. To meet this objective, Wave 1 respondents were asked about: (1) their awareness of the TIP series and of specific TIPs prior to receiving the Wave 1 survey;³ (2) their knowledge of how, and their perception of the ease with which, to obtain a hard copy of a specific TIP; (3) perceived barriers to obtaining and sharing TIPs; (4) how they first heard of the TIP series; (5) sources for finding out about developments in the SA treatment field; (6) sources used to discuss TIPs, and (7) potential dissemination mechanisms for TIPs.

3.2. Awareness of the TIP Series and specific TIPs

Of the 3,267 respondents who returned a Wave 1 survey, 44.9% were previously aware of the TIP series. When awareness of the series was examined by respondent group, significant differences among the job classifications emerged [$F(3, 3267) = 84.34, p \leq .001$]. All SSA Directors were previously aware of the TIP series prior to receiving the Wave 1 survey. Less than half of the remaining groups were previously aware of TIPs (49.6% of Facility Directors, 45.4% of Clinical Supervisors, and 38.5% of Program Counselors, respectively).

Those respondents who were previously aware of the TIP series were asked to mark which of the 28 specific TIPs they had heard. From this, it was determined whether the respondent had heard of *any* of the 28 specific TIPs. Of those respondents who were previously aware of the TIP series, 91.3% reported hearing of at least 1 of the 28 specific TIPs.

3.3. Knowledge of how, and ease with which, to obtain a hard copy of a specific TIP

Although no direct marketing of TIPs had occurred at the time of the study, 57.1% of respondents claimed to know how to obtain a hard copy of a specific TIP. In addition, 53.5% of respondents reported that it was “easy” or “very easy” to obtain a specific TIP compared to 3.9% who believed it was “difficult” or “very difficult” to obtain a specific TIP.

3.4. Barriers to obtaining and sharing TIPs

Respondents were asked to identify, from a series of 11 items, all barriers that affect their ability to obtain and share TIPs with others (See Table 2). From this list, 29.4% of respondents selected the option, “no barrier to obtaining and sharing TIPs.” Among those who selected barriers, lack of knowledge regarding the circumstances surrounding the obtaining of TIPs was the most frequently identified barrier. Specifically, 45.5% of respondents did not know when new TIPs are published and 18.3% reported they did not know how to obtain TIPs. Other interesting results included respondents who reported they never tried to get one (even though they were aware of the series) and having no money to buy them (TIPs are free).

³This question also served as a screener question (1) to reduce the sample to only those individuals who had heard of TIPs and (2) to identify those individuals who were to receive Wave 2 of the survey, which focused on specific TIPs they had used. Unless otherwise indicated, the remaining results pertain only to those individuals who were aware of the TIP series prior to the data collection efforts of this study.

...INSERT: Table 2. Barriers to obtaining and sharing TIPs

3.5. How respondents first heard of the TIP Series

Almost a quarter of the respondents (24.9%) marked that they first heard of TIPs from a National Clearinghouse for Alcohol and Drug Information (NCADI) staff or publication. Other primary sources for first hearing about TIPs included at a conference/workshop/training, unsolicited from CSAT/State AOD agency, and from a colleague (See Table 3).

...INSERT: Table 3. How respondents first heard about the TIP Series

3.6. Sources for finding out about developments in the SA treatment field

To determine how treatment providers typically find out about developments in the SA treatment field, respondents were asked how often they relied on various sources for learning about developments in the field (See Table 4). The most frequently reported source for learning about developments in the treatment field was through informal conversations with other treatment professionals. Other top sources for hearing about developments in the field were through journals, newsletters, or other professional publications; participation in training sessions, seminars, workshops, or technical assistance; and/or attendance at conferences or meetings of professional or provider associations.

...INSERT: Table 4. Mean likelihood of using each source to hear about developments in the SA treatment field

3.7. How often respondents heard of TIPs from a variety of sources in the past 5 years

To determine whether TIPs are being discussed by treatment professionals through the same sources used to find out about other developments in the field, respondents were asked how often they heard of a TIP, or the TIP series, through a variety of sources in the past 5 years.⁴ Similar sources (e.g., informal conversations, attendance at conferences and meetings, participation in training sessions and workshops, etc.) are being used to discuss TIPs as are being used to find out about other developments in the field (See Table 5). However, the same sources are being used much less frequently to discuss TIPs than they are being used to find out about other developments in the field. An examination of the mean frequency with which treatment professionals are using these sources to discuss TIPs reveals that respondents “rarely” heard about TIPs through these sources in the past 5 years (See Table 5).

...INSERT: Table 5. Mean likelihood of hearing of TIPs through various sources in the past 5 years

3.8. Potential CSAT dissemination channels

⁴The same five point Likert scale, which was used to ask respondents how often they used a variety of sources to hear about developments in the SA treatment field, was used: 1=Never 2=Rarely 3=Sometimes 4=Frequently 5=Very Frequently.

The sources discussed in the preceding section represent potential dissemination channels for TIPs. In addition to these channels, CSAT currently sponsors several mechanisms that can potentially be used to increase awareness and/or use of TIPs. These mechanisms range from participation in the TIPs development process to participation in a variety of CSAT sponsored activities (e.g., conferences, technical assistance, trainings).

TIPs are developed through a consensus panel process and, prior to their release, reviewed by members of the treatment field. The Retrospective Study revealed that very few treatment professionals (20.1%) who were aware of the TIP series were aware of the consensus panel process.

In addition to the TIPs development process, CSAT sponsors three other activities that are potential TIPs dissemination mechanisms. These activities include conferences, technical assistance (TA), and courses at Addiction Technology Transfer Centers (ATTCs). Respondents were asked if they had attended a CSAT sponsored conference in the past five years. Of those who were aware of the TIP series, 29.4% of respondents reported attending a CSAT sponsored conference during the past 5 years.⁵ Respondents who reported attending a CSAT sponsored conference were asked whether TIPs were disseminated or discussed in any of the workshops or presentations; 74.5% of respondents who attended a conference claimed TIPs were disseminated or discussed in the workshops or presentations.

Similar to CSAT sponsored conferences, the provision of CSAT sponsored technical assistance (TA) offer another potential mechanism to disseminate TIPs. Of those who were aware of the TIPs series, 18.4% reported receiving CSAT sponsored TA in the past five years. Of these individuals, 63.0% reported that TIPs were used as a provision of this TA.

A final potential dissemination mechanism that CSAT has for increasing awareness of TIPs is through the curricula and courses provided by CSAT sponsored Addiction Technology Transfer Centers (ATTCs). When asked if they had attended a course at an ATTC in the past 5 years, 8.9% of respondents who were aware of the TIP series reported that they had. When asked how the course involved TIPs, 56.9% of those who attended an ATTC course claimed TIPs were used as either optional (21.1%), supplemental (27.6%), or required reading (8.1%). Twenty-four per cent of respondents reported the course did not involve a TIP, and roughly 19% could not remember.

3.9. Attitudes toward TIPs

The second objective of the Retrospective Study was to determine whether TIPs contain information appropriate for use by the treatment field. To meet this objective, treatment professionals' attitudes toward the TIP series were assessed. To determine treatment provider's

⁵ Because most conference attendees are unaware of the funding source of a conference, it is possible that the respondents may have under-reported attending a CSAT sponsored conference. Therefore, these low figures may be more reflective of recall or lack of knowledge rather than true conference attendance.

attitudes toward TIPs, respondents were asked 17 attitude questions along three dimensions—TIPs’ content and nature, their reader/user-friendliness, and their applicability.⁶ In terms of respondents’ attitudes toward the content and nature of TIPs, treatment providers generally agreed that TIPs are credible (O = 4.27, SD = 0.68), research-based (O = 4.03, SD = 0.71), contain timely information (O = 4.02, SD = 0.76), comprehensive information (O = 4.09, SD = 0.76), new information (O = 4.16, SD = 0.80), and information relevant to their programs (O = 4.19, SD = 0.80). They were a little less certain, however, if the TIP series is culturally sensitive (O = 3.80, SD = 0.79).

When attitudes toward the reader and user-friendliness of TIPs were assessed, respondents generally agreed that TIPs are an important addition to the field (O = 4.01, SD = 0.78), use language that is easy to understand (O = 4.10, SD = 0.72), have a format that is easy to read (O = 4.00, SD = 0.76), and are packaged and presented in an appealing way (O = 3.88, SD = 0.82). Similar to their attitudes toward the content of nature of TIPs, respondents were less certain that TIPs use language that is culturally relevant (O = 3.74, SD = 0.79).

Although respondents reported generally positive attitudes toward the content and nature and reader/user-friendliness of TIPs, they reported less positive attitudes when asked about their ability to implement TIPs into practice. When asked about the applicability of TIPs, treatment providers reported attitudes between “neither agree nor disagree” and “agree” with the comments: TIPs has provided information that is used by other programs I have observed or know about (O = 3.72, SD = 0.86), TIPs are relevant to diverse treatment populations (O = 3.94, SD = 0.74), TIPs provide clear guidance about administrative and/or clinical practices (O = 3.78, SD = 0.77), TIPs provide guidelines our program can afford to implement (O = 3.70, SD = 0.84), and TIPs have been used to improve our program’s administrative or clinical practices (O = 3.67, SD = 0.90).

3.10. Practices: Respondents’ use of TIPs

The third objective of the Retrospective Study sought to determine the degree to which readers use TIPs, and the impact of TIPs on the SA treatment field. The Wave 1 survey contained 2 items designed to measure respondents’ use of the TIP series. The first question asked respondents to mark which, if any, of the 28 specific TIPs his/her organization had used in training or curriculum development. The second question asked respondents to mark which, if any, of the 28 specific TIPs had been used by their organization to promote or effect organizational change. Of the 1,468 respondents who were aware of the TIP series, 62.5% reported using at least 1 of the 28 specific TIPs in training or curriculum development. Similarly, 62.9% of respondents reported using at least 1 of the 28 specific TIPs to promote or effect organizational change.

4. Wave 2 results

⁶The following scale was applied to the response options: 1=Strongly Disagree 2=Disagree 3=Neither Disagree Nor Agree 4=Agree 5=Strongly Agree.

The Wave 2 survey focused primarily on objective 3 of the Retrospective Study by asking respondents to provide feedback regarding their dissemination and use of a TIP they found particularly useful (i.e., a most useful TIP) and on another TIP they found less useful than the other TIPs (i.e., a least useful TIP). Of the 1,028 respondents who returned a Wave 2 survey, only 877 indicated a specific TIP that was most useful to them. Similarly, only 408 respondents indicated a specific TIP that was less useful to them than the other TIPs. The sample size is thus 877 for questions regarding the most useful TIPs and 408 for questions regarding the least useful TIPs.

4.1. Dissemination of the most useful TIPs to others

The Wave 2 survey asked respondents a series of questions regarding whether or not they disseminated useful TIPs to others. Of those who selected a most useful TIP, 70.9% of respondents claimed they shared the most useful TIPs with others.

Respondents who indicated they shared the most useful TIPs with others were asked with whom they shared the most useful TIPs. Overall, respondents were most likely to share useful TIPs with co-workers/colleagues and with middle managers (see Table 6). Facility Directors and Clinical Supervisors were also likely to share useful TIPs with Counselors (see Table 6).⁷ Similarly, Facility Directors and Program Counselors were likely to share useful TIPs with Clinical Supervisors.⁸

...INSERT: Table 6. Individuals with whom respondents shared the most useful TIPs (N=619)

Finally, respondents who indicated they shared useful TIPs with others were asked if they recommended that others implement the guidance contained in the useful TIPs. Over half the respondents (57.8%) reported that they recommended that others implement the guidance contained in the useful TIPs.

4.2. Personal use and organizational implementation of the most useful TIPs

4.2.1. Personal use of the most useful TIPs

To determine how respondents used the most useful TIPs, respondents were asked two questions. First, respondents were asked when they last used the most useful TIPs. Just under 96% of respondents (95.9%; N=869) reported using the most useful TIPs. Of these individuals, 83.8% used the most useful TIPs within the last year. Respondents who indicated they used the most useful TIPs were then asked, via an open-ended response question, to describe how they used the TIPs.

⁷ Only the Facility Directors and Clinical Supervisors were given the option of selecting ‘Counselors.’

⁸ Only the Facility Directors and Program Counselors were given the option of selecting ‘Clinical Supervisor.’

Two hundred and sixty-eight Facility Directors, two hundred and sixty-six Clinical Supervisors, two hundred and thirty-two Program Counselors, and twenty-seven SSA Directors responded to this question. A content analysis was conducted on respondent groups' answers. Major categories resulting from a content analysis of responses revealed all respondent groups used the most useful TIPs to: (1) obtain treatment information (mostly as a reference); (2) for training; and (3) to develop and/or change programs and policies. Clinical Supervisors and Program Counselors also used the most useful TIPs in treatment (i.e., to screen and assess clients).

4.2.2. Organizational implementation of the guidance contained in the most useful TIPs.

After respondents were asked to report their personal use of the most useful TIPs, they were asked a series of questions designed to assess: (1) if the guidance contained in the most useful TIPs had been implemented at the organizational level; and (2) if it had, the impact of using the most useful TIPs in practice.

First, respondents were asked if they or their organizations had implemented the guidance contained in the most useful TIPs. Of the respondents who answered this question (N=869), 61.0% indicated that they, or their organizations, had implemented the guidance contained in the most useful TIPs; 27.7% of respondents indicated that they, or their organizations, had not implemented the guidance contained in the most useful TIPs; and 11.3% indicated that they did not know if the guidance was implemented at the organizational level.

Respondents who stated that they, or their organizations, implemented the guidance from the most useful TIPs were asked to select from a list of ten possible actions those actions that their organizations attempted to implement. As indicated in Table 7, respondents were most likely to use useful TIPs to implement changes in administrative or clinical practices; to plan or initiate new programs, to modify program policy, to improve linkages with other service system components, and/or to monitor patient outcomes.

...INSERT: Table 7. Actions attempted using guidance contained in most useful TIPs (N=530)

In order to determine the impact of using the most useful TIPs on the treatment field (i.e. Objective 3 of the study), respondents were asked to select the most significant action they, or their organizations, attempted to implement. Respondents were then asked several questions about the effectiveness of implementing that most significant action. Table 8 lists, in descending order, the most significant actions respondents chose. Modifying administrative or clinical practices, planning or initiating programs, and improving linkages with other service system components were the three most significant actions selected.

...INSERT: Table 8. Most significant action selected by respondents (N=513)

After respondents selected the most significant action they, or their organizations, attempted to execute, they were asked to characterize the results of attempting to implement the most significant action using a 5-point Likert scale with 1 indicating 'very negative' and 5 indicating

‘very positive’.⁹ Overall, respondents reported the results of their actions were somewhat positive ($M=4.33$, $SD=0.60$). Very few respondents (0.4%) reported negative results from implementing the most significant action (see Figure 1).

...*INSERT: Fig. 1.*

Next, respondents were asked to select all barriers they experienced in attempting to implement the guidance in the most useful TIPs. As indicated in Table 9, the most frequently marked barriers to implementing the guidance contained in the most useful TIPs included: ‘staff resistance,’ ‘financial/costs restriction,’ ‘staff not trained to implement,’ and ‘client/patient resistance.’ Less than a quarter of respondents (22.6%) indicated there were ‘no barriers’ in attempting to implement the guidance contained in the most useful TIPs.

...*INSERT: Table 9. Barriers to implementing most significant action (N=513)*

After respondents were asked to indicate the barriers they experienced in attempting the action, they were asked if the guidance implemented from the most useful TIPs was still in use. Of the 513 respondents who said they, or their organizations, had attempted to implement a specific action, 93.6% reported that the action was still in use.

Finally, respondents who indicated that the guidance or information implemented from the most useful TIPs was no longer in use ($N=32$), were asked to indicate the reasons for the guidance or information no longer being used. As indicated in Table 10, the most frequently selected response for why the guidance/information is no longer in use was that the action was accomplished and that the guidance was no longer needed. The second most frequently selected response was ‘other.’ Respondents who selected ‘other’ were asked to provide their reasons in the space provided. The six respondents who selected ‘other’ stated that: (1) changes in leadership, (2) changes in staff, (3) changes in treatment modality, (4) changes priority, (5) the fact that they left their position, and (6) the fact that the program closed were the reasons that the guidance or information was not still in use. Of the 10 possible reasons listed on the survey, half of them (provider resistance, outdated science/practice, internal SSA staff resistance, staff resistance, board resistance, and client resistance) were not selected by any respondent.

...*INSERT: Table 10. Reasons for most significant action not being used anymore (N=32)*

4.3. Least useful TIPs

After respondents were asked about their dissemination and use of a TIP they found particularly useful, they were asked to select a specific TIP that was less useful to them than the other TIPs (i.e., a least useful TIP) and report, via open-ended response questions, (1) what they liked least about the least useful TIP, and (2) how they would change the least useful TIP to make it more useful to them.

⁹The values for the 5-point Likert scale were as follows: 1=Very negative, 2=Somewhat negative, 3=Neither negative nor positive, 4=Somewhat positive, and 5=Very positive.

4.4. What respondents liked least about the least useful TIPs

Eighty-seven Facility Directors, eighty Clinical Supervisors, eighty-seven Program Counselors, and fourteen SSA Directors provided comments regarding what they liked least about the TIP they selected as less useful to them than the other TIPs (i.e., the least useful TIP). Major categories resulting from a content analysis conducted on these responses indicate that treatment professionals dislike: (1) the content of the least useful TIPs, (2) the format of the least useful TIPs, (3) the fact that the least useful TIPs are incompatible with considerations that must be made at the organizational level (i.e., treatment organization considerations), and (4) the fact that the least useful TIPs are difficult to implement.

All respondent groups disliked aspects of the content of the least useful TIPs. Lower order themes revealed that treatment professionals believed the content of the least useful TIPs was not comprehensive enough for their needs. Higher order themes revealed that all four respondent groups thought the content of the least useful TIPs was not useful and not updated. All four respondent groups also requested new topic areas or additional information on topic areas already presented in the least useful TIPs. Facility Directors and Clinical Supervisors commented that they disliked the implementation guidance provided in the TIP. Clinical Supervisors and Program Counselors thought the least useful TIPs were culturally insensitive and biased towards urban areas.

In addition to disliking various aspects of the content of the least useful TIPs, major categories revealed that Facility Directors, Program Counselors, and SSA Directors disliked various aspects of the format of the least useful TIPs. Facility Directors and Program Counselors thought the least useful TIPs were too long. Facility Directors also commented that it was difficult to locate specific information within the TIPs and that the least useful TIPs were difficult to read. Program Counselors thought that the least useful TIPs were too wordy and were presented in a bland way, and SSA Directors thought the least useful TIPs were targeted to too specific of a target audience.

A third major category revealed all respondent groups believed considerations which must be addressed within their treatment organization (i.e., treatment organization considerations) prevent them from using the TIPs in practice. All respondent groups indicated that lack of resources (e.g., money) made it difficult to implement the guidelines contained in the least useful TIPs. Respondent groups also felt the least useful TIPs were incompatible with the existing infrastructure, with their current environment, with State and organizational guidelines, and with the immediate needs of their treatment population.

4.5. Recommended changes to the least useful TIPs

After respondents were asked what they disliked about the least useful TIPs, they were asked how they would change the least useful TIPs to make them more useful to them. Sixty-six Facility Directors, seventy Clinical Supervisors, sixty-nine Program Counselors, and eight SSA Directors provided suggestions on how to improve the least useful TIPs. Major categories

revealed that all respondent groups recommended changes to the content and to the format of the least useful TIPs. In addition, Clinical Supervisors and Program Counselors recommended changes to the least useful TIPs in order to make them more compatible with current treatment organization considerations.

All respondent groups recommended changes to the content of the least useful TIPs. All respondent groups requested additional content (e.g., new topic areas or additional information on current topic areas); updated content; and a more comprehensive content. Facility Directors and Clinical Supervisors wanted additional tools to be included in the TIPs. Clinical Supervisors, Program Counselors, and SSA Directors requested that the information be more research based.

In addition to recommending changes to the content of the least useful TIPs, respondents also recommended changes to the format of the TIPs. Facility Directors, Program Counselors, and SSA Directors suggested alternative formats. Facility Directors and Program Counselors recommended the least useful TIPs be provided in video format; SSA Directors requested a training format. Program Counselors and SSA Directors requested the least useful TIPs be shorter. Clinical Supervisors suggested modifications to the current format. Recommendations included larger print and a clearer format.

Finally, Clinical Supervisors and Program Counselors recommended changes to the least useful TIPs that would make them more compatible with current treatment organization considerations. Clinical Supervisors requested that the TIPs address Managed Care costs and that CSAT provide staff training. Program Counselors made general comments regarding the need for the least useful TIPs to be compatible with the treatment organizational structure. Both Program Counselors and Clinical Supervisors requested a more cost effective method of implementing the least useful TIPs into practice.

5. Discussion

The Retrospective Study was designed to understand the extent to which the TIPs program has influenced best practices in the SA treatment by measuring respondents' knowledge (i.e., awareness), attitudes, and practices regarding the TIP series and the 28 specific TIPs, which were published at the time of the survey. Results from the Retrospective Study provide valuable information that can be used to make modifications in the development and dissemination of TIPs. Improvements in the way TIPs are developed and disseminated will likely lead to increased use of TIPs in practice. Results will be discussed in terms of their implications for the TIPs program. Specifically, recommendations regarding the development, dissemination, and implementation of TIPs will be made.

5.1. Development of TIPs

Results from the Retrospective Study indicate that although treatment professionals like TIPs, many treatment professionals believe improvements in TIPs can be made. Treatment professionals requested changes to the content and format of TIPs that will make them easier to

read and use. Although treatment professionals like the fact that the TIPs are research based, they have neither the time, nor the desire, to read lengthy technical documents. If TIPs are to be used in practice, technical information will need to be condensed. In addition, creating summaries of important points and including indexes and/or quick reference guides will make TIPs easier to read.

Treatment providers also expressed a concern about the currentness of the information contained in some TIPs. Furthermore, several of the selected “least useful” TIPs were published almost ten years ago. Because knowledge of best practices in SA treatment is changing at a rapid rate, it is important that the information in TIPs be kept up-to-date. In addition, because some of the information contained in TIPs is time sensitive, the information in all TIPs should be monitored to ensure the information contained in them does not become obsolete. When the guidance contained in an entire TIP is no longer considered a “best practice” in SA treatment, that TIP can be revised to reflect current best practices in the field. Because revising a TIP takes time, when only a portion of a TIP becomes out-dated, the outdated portion of the TIP can be supplemented, or replaced, with best practice “updates.”

Finally, lack of cultural sensitivity of TIPs is a recurrent theme throughout study results. Treatment professionals question whether TIPs are culturally sensitive and whether the information contained in them can be implemented in culturally sensitive ways. New TIPs, and technical assistance activities for existing TIPs, must show awareness of cultural differences, must address these differences, and must contain information on how to implement the information contained in TIPs in culturally sensitive ways.

5.2. Dissemination of TIPs

Results indicate that TIP awareness levels among treatment professionals are relatively low. Therefore, increasing awareness of TIPs is a likely first priority. Survey results provide evidence to support various mechanisms for increasing awareness of TIPs.

First, all treatment professionals will need to be targeted for increased TIP awareness. Although half of all treatment professionals became aware of TIPs without a direct marketing plan, the other half the treatment field still needs to become aware that TIPs exist. In addition, Program Counselors, who have the greatest potential to use TIPs with clients, have the lowest TIPs awareness levels. Therefore, Program Counselors should be targeted specifically for increased awareness.

Second, results suggest that an aggressive marketing strategy is likely to improve TIPs awareness levels. The number one complaint of providers who are aware of TIPs is they do not know when new TIPs are published. New TIPs, and revisions to older TIPs, need to be marketed so that all providers become aware of their publication. One possibility is to send announcements to all treatment programs in a State when new TIPs become available.

Third, many providers first heard of TIPs through the National Clearinghouse for Alcohol and Drug Information (NCADI). Therefore, NCADI can be instrumental in increasing awareness of

TIPs. Mentioning TIPs to callers or sending a list of all published TIPs with orders for comparable materials can reach many individuals in a relatively short period of time. Using NCADI as a mechanism to increase awareness would also be cost efficient since it is already under Federal contract.

A fourth way to increase awareness of TIPs is to disseminate TIPs through CSAT sponsored activities. The Retrospective Study found that treatment professionals who participated in CSAT sponsored activities reported that TIPs are being used during these activities. However, strategies for increasing attendance at these activities may need to be incorporated into a dissemination plan because the number of providers who participate in these activities is relatively low.

Capitalizing on interpersonal channels will also improve awareness of TIPs. Results indicate that the most often reported way that treatment professionals share information within the field is through interpersonal communication channels. Results also indicate that although treatment professionals find out about developments in the field through interpersonal channels, they rarely discuss TIPs through these same channels. Treatment professionals, when they do discuss TIPs, share TIPs with their coworkers, colleagues, counselors, middle managers, and supervisors. These findings indicate treatment professionals tend to share TIPs with individuals who work within their organizations, but share TIPs less frequently with individuals who work outside their organizations. Thus, targeting treatment professionals within their facilities will likely lead to increased overall awareness of the TIP series.

Finally, if opinion leaders (i.e., respected individuals) within treatment organizations can be identified, then these individuals can be enlisted as dissemination agents for TIPs. The current TIPs dissemination plan includes sending TIPs, immediately upon publication, to SSA Directors and asking the SSA Directors to disseminate TIPs among the ranks of the treatment field. Results indicate that although SSA Directors are sharing TIPs with others, they are not sharing TIPs with the Program Counselors working at treatment programs in their State. Thus, SSA Directors may not be the best dissemination agents for TIPs if the goal is to increase TIPs awareness amongst the Program Counselors. Because treatment professionals report sharing TIPs most often with their colleagues and coworkers, identifying opinion leaders within specific treatment programs, and enlisting these individuals as dissemination agents for TIPs, will likely be more effective in increasing TIPs awareness levels, especially amongst Program Counselors.

5.3. Use of TIPs

Once TIPs awareness levels increase, focus will need to shift to assisting treatment professionals in using TIPs in practice. The primary concern treatment professionals have regarding TIPs is their uncertainty as to whether they are able to implement the information contained in TIPs. Barriers to implementing TIPs such as lack of money, the questionable cultural sensitivity of TIPs, and considerations that need to be made at the organizational level, are several reasons for this uncertainty. If the goal is to have treatment professionals use TIPs, then providers will need help moving beyond barriers to implementation and be taught how the information contained in TIPs can be implemented within their organizations.

Before treatment professionals can use TIPs in practice, they will need to learn the skills necessary to implement the guidance contained in TIPs. Lack of staff training to implement a given treatment practice is one of the primary barriers reported by treatment professionals when trying to implement TIPs. As a first step to teaching treatment professionals best practices in SA treatment, TIPs-based trainings will need to be developed and disseminated. One way of doing this is to send the curriculum (i.e., training) directly to treatment programs with instructions on how to use it. Train-the-trainer workshops using the TIPs-based trainings can also be conducted. When professional trainers learn how to teach best practices in SA treatment, they can return to their States, or to their programs, to teach larger numbers of treatment professionals what they have learned.

In addition to lacking the skills necessary to use the guidance contained in TIPs in practice, treatment professionals reported difficulty in implementing the guidance contained in TIPs in their organizations. Reasons for this difficulty stem from the guidance being inconsistent with considerations that need to be made at the organizational level. Because treatment professionals will not use TIPs unless the information contained in them is consistent with the regulations, resources, and philosophy of their particular organization, treatment professionals will also need to be taught how to implement the guidance once they have learned it. One way to do this is to develop TIPs-based implementation trainings. If this method proves cost prohibitive, implementation modules can be incorporated within the TIPs-based trainings discussed above. If implementation modules are included in typical training packages, these modules will need to address primary implementation concerns among treatment professionals.

6. Conclusion

In conclusion, the Retrospective Study was designed to evaluate the Federal government's efforts at developing and disseminating best practice guidelines for SA treatment. Rigor in the developmental and implementation phases of the study, as well as extremely high response rates, provide confidence in the generalizability of the research results to the administrators and line staff working in State recognized treatment facilities. The Retrospective Study represents the largest body of market research to date regarding the success of the TIPs program and the needs of the treatment field. Results of the study can be used to determine how, if, and to what extent the content, format, and dissemination of TIPs should be changed. Modifications in the development and dissemination of TIPs will ensure efficient allocation of Federal funds, which will aid in the delivery of best practices in SA treatment.

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Table 1
Response Rates for Wave 1 and Wave 2 Questionnaires

Respondent Group	Wave 1 (N=3,267)	Wave 2 (N=1,028)
SSA Directors	81.5	68.9
Facility Directors	81.5	70.2
Clinical Supervisors	79.9	77.8
Program Counselors	79.1	75.2

Figure 1
**How Positive Were the Results of Attempting to Implement
the Most Significant Action?**

