Writing an All-Qualitative R01: In Pursuit of Rigor in a Study of Dual-Diagnosed Homeless

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Background to the Study: Housing First vs. Treatment First

Pathways to Housing

Clients: **Axis I dx/severe mental illness**
Chronic homelessness
90% alcohol or drug abuse

Services:

- **'Housing First'; consumer choice**
- **ACT teams**
- **Harm reduction**
- **Vocational rehabilitation/Job Training**
- **On-site health clinic**
- **Classes (photography, creative writing)**
- **Money Management (30% of SSI>rent)**

NEW YORK HOUSING STUDY (n=225)

Sample and Criteria:

- Axis-I diagnoses or Axis-II diagnoses with functional impairment
- History of homelessness of at least six months (spent at least 15 of the past 30 days literally homeless on the streets or in other public places other than shelters)
- No exclusion criteria

BASELINE	EXP %	CONTROL %	X^2
Psychiatric Dx			2.77
Psychotic	60	64	
Mood - depr	21	13	
Mood - bi	13	18	
Other	6	5	
Ever arrested	68	62	0.81
Drug use/6 mos	28	26	0.12
Alco use/6 mos	40	40	0.00
Heavy drug use	22	19	0.34
Heavy alco use	16	15	0.05

Outcomes At 6- And 12-Month Follow-Up Assessments

	6 months		12 months	
	Exp. (n=93)	Con. (n=104)	Exp. (n=91)	Con. (n=113)
A. Categorical Variables	%	%	%	%
Drug use last 6 months	23	22	23	25
Alcohol use last 6 months	42	47	45	38
Heavy drug use	16	12	18	19
Heavy alcohol use	08	16*	12	13
Receive federal benefits	85	64 ***	83	69 **

*p<.10; **p<.05;***p<.001

Outcomes At 6- And 12-Month Follow-Up Assessments (cont'd)

B. Continuous Variables Mean (s.d.)

	6 months			12 months	
	Exp. (n=93)	Con. (n=104)		Exp. (n=91)	Con. (n=113)
Colorado Symptom Index (1-5)	2.2 (0.9)	2.3 (0.9)		2.2 (0.9)	2.2 (0.9)
Quality of life (1-7)	4.7 (1.5)	4.3 (1.5)	**	4.8 (1.5)	4.7 (1.4)
Health (1-4)	2.4 (1.0)	2.5 (0.9)		2.3 (0.9)	2.3 (1.0)
Mean proportion of time in stable housing/ past 6 months				.80 (.34)	.23*** (.37)

*p < .10. ** p < .05. *** p < .001

A Sequential Approach to Mixing Methods: Next Steps in the New York Housing Study

Unanswered Questions from the NYHS:

- Lack of difference in drug/alcohol use
  (yet comparing 'harm reduction' to 'abstinence')
- No significant differences in self-rated health and QOL
- An artifact of measurement limitations or 'real'?
- What factors influence use or non-use of drugs/alcohol in this population?
- Why are psychiatrically disabled homeless adults (PDHAs) so resistant to or alienated by the service delivery system?

August, 2002: A Program Announcement!!!

Joint from NIMH,NIAAA,NIDA PA-150
Services for Homeless Persons with Dual Diagnoses
Understanding the Service System from the User's Perspective

- Unclear how (if at all) program type affects use of d/a svcs
- Available research has brought precision at the cost of narrowed scope, i.e., a 'top down' perspective on the gap between need and use of services among PDHAs
- Studies have been *thorough* in measuring the prevalence of problems and *focused* in testing interventions for their resolution, but they have also been *partial* in perspective
- The service user's perspective remains poorly documented and understood.

The Journey of an all-qualitative R01

- February 1, 2003—First submission
- July, 2003-Ad Hoc Study Section meets
- August, 2003-Summary Statement received;

24th Percentile ranking but minor criticisms

- September, 2003-NIMH Council approves for funding
- September-October, 2003-Celebration ☺☺

Next Steps in the Journey

- October, 2003--Budget cuts at NIMH—no funding ☹☹
- October, 2003--Revise and resubmit proposal
- January, 2004—Informed font and size too big
  - Must revise within a week in Arial font
  - Requires cutting two pages out of proposal and reformatting everything
- March, 2004—Study Section meets to review revision
- April, 2004—Summary Statement received: 1.5 Percentile!
- May, 2004—NIMH Council approval not needed
- Celebration, part 2 ☺☺

The “endless” journey to getting an NGA

- July, 2004.—Budget office asks to start grant on July 15 (10 days hence)
- July 19, 2004—PI told to respond to Summary Statement criticism asap
- July, 27, 2004—NIMH Grants office says did not receive Human Subjects Certification and other required forms (faxed on July 7)—updated Other Support, etc.
- July 29, 2004—Forms re-sent to Grants office
- August 3, 2004—NIMH grants manager says still needs Consortium Agreements must be updated and overhead rates, etc. Stay tuned….

Study Questions

When confronted with two distinct service approaches to engagement and retention in care, how do PDHAs respond? How do these responses--and the use or avoidance of services--evolve over time?

What factors—*person-based* and *contextual*—determine successful engagement and retention in care among PDHAs enrolled in these contrasting program models? What factors impede this process?

Theoretical/Conceptual Framework

- Social Ecology (e.g., Bronfenbrenner)
- Symbolic Interactionist (Blumer; Becker)
- Empowerment and Choice
- Capabilities (Nussbaum)

Specific Aim 1
Retrospective Life History Phase

To map 'successful' vs. 'unsuccessful' life course trajectories of engagement and retention in care among PDHAs enrolled in two contrasting programs—'housing first' vs. 'treatment first'

Methods:

- **In-depth interviews; retrospective life histories**
- **Use of 'life chart' review**
- **N=40 participants from the NYHS (20 control; 20 experimental)**
- **Nominated by NYHS staff by criteria of 'success' or 'failure' in controlling drug/alcohol use: consensus nominations**
- **Retrospective case study analysis: Cross-case analysis**

Specific Aim 2
Prospective Study Phase

To conduct a longitudinal mixed methods study of PDHAs enrolled in 'housing first' vs. 'treatment first' programs to learn how engagement and retention in care vary when program philosophies and practices fundamentally differ.

Methods:

- **Prospective (1 year) follow-up of 80 enrollees in 3 programs (1 'housing first'; 2 'treatment first')—3 in-depth interviews each**
- **In-depth interviews with case managers at 3 programs (n=80)**
- **Focus groups of staff at the 3 programs**
- **Grounded Theory analysis**
- **Additional use of some standardized measures**

Specific Aim 3
Translation and Dissemination Phase

To specify viable changes in delivery of services that would result in successful engagement and retention of PDHAs in care for mental illness and co-morbid substance abuse.

Methods:

Expert panels (focus groups) of:

- **providers in mental health, substance abuse, and homeless services;**
- **service consumers**
- **Not 'research' data**

Background and Significance Section: Outline

2.1 Treatment and Rehabilitation Needs of PDHAs

2.1.1 Service Delivery for PDHAs: Searching for the Right Fit

2.1.2 Research on Engagement and Retention in Psychiatric Care for PDHAs

2.1.3 Research on E+R in Substance Abuse Treatment for PDHAs

2.2 Studies of the "Process" of Care: The Need for Qualitative Methods

2.3 Examining Intra-Group Variation: Gender, Age, and Ethnicity

2.4 Qualitative Studies of PDHAs

2.5 Theoretical and Conceptual Frameworks for the Proposed Study

Methods Overview

4.1 Overview. Qualitative methods, recognized for their ability to 'go where quantitative designs cannot' [53, p. 159], are ideally suited to this study. We will use minimally structured interviews with PDHA consumers in Aims 1 and 2 and supplementary interviews of providers under Aim 2. Specific Aim 2 will follow a mixed method (dominantly qualitative) approach by using selected quantitative measures. Specific Aim 3 will not involve formal data collection but will be the 'intensive translation and dissemination' phase of the project.

Following each interview, interviewers will complete a facesheet (date/place/length of interview, R's date of birth, sex, age, ethnicity, program site, address), log observational data, transcribe the audiotape, and present a 'case summary' for review by the research team during regular weekly meetings. These case reviews will provide a forum for interim analysis and to identify leads for follow-up interviews. Observational data will come from field notes logged immediately after the interview to capture non-verbal information as well as observations of R's demeanor, affect, etc. In our experience, these notes add a level of depth to the data coming from transcripts [86-87].

Strategies for Rigor

Aim #1: Triangulation of Data (Life hx interviews, Life Chart, NYHS Quant. Data)

- Co-coding
- Auditing
- Member checking

Aim #2: Prolonged engagement (12 month followup)

- Auditing
- Triangulation of data
- Negative case analysis

Reviewers' Critique: Summary Statement

1) **The conceptual foundations are not apparent in the specific aims /instrumentation; there is a disconnect between the empowerment/choice orientations and success/failure terminology.**
2) **Absence of full membership by a consumer/ survivor/ex-patient on the Advisory Panel and the tasks of the Panel are not specified.**
3) **What if respondents object to their portrayal in the case studies**
4) **A table is needed identifying participants, data collection sources and techniques, and time frame by Study Aim.**

Summary Statement, cont'd.

5) Inclusion of policymakers from government and medical systems under Aim 3.

6) Lack of inclusion of the most severely disenfranchised patients, i.e., those 'outside' the system.

7) Need for more specifics on how results from the retrospective study (Aim 1) will inform the prospective study (Aim 2).

Strengths of the Proposed Study

- This study includes retrospective *and* prospective designs and deploys two of the most systematic and respected approaches in qualitative methods: case studies and grounded theory.
- Our research team is inter-disciplinary, strong in qualitative methods, and has already-established working relationships from previous collaborations. A multi-disciplinary perspective is especially important in qualitative methods since it broadens the basis for interpretations and offers greater opportunities for challenges to within-discipline assumptions [92].
- By examining case studies of failure as well as success in engagement and retention, we offer more options for sensitive *and* specific identification of factors.

Strengths, cont'd.

- This study has a built-in translation and dissemination component to ensure that these important activities occur. Our pursuit of an active practice-research partnership throughout the study offers further grounding in the real-world of service delivery.
- We have made a concerted effort to focus on intra-group variation in sampling and in the analyses so that vulnerable subgroups of PHDAs defined by gender, age, etc. are not overlooked.

Key Components of the Study

- Multi-disciplinary team (social work; anthropology; psychology; psychiatry)—previous NIH funding
- Strong previous research (NYHS) and continuity with it
- Inclusion of PDHA consumers in Advisory Panel
- Detailed Methods and Analysis sections

Implications of a Qualitative Study of Dual-Diagnosed Homeless and Service Delivery

- PRACTICE- ***Engagement and retention in care--*** help providers improve skills, reduce treatment dropout and maintain client trust; help programs integrate services; expand Assertive Community Treatment to include housing/consumer choice
- POLICY—***Services for substance abusing homeless mentally ill***—funding for housing first vs. treatment first; promote the integration of mental health, substance abuse and health care services; harm reduction program philosophies

- RESEARCH—***Utility of qualitative methods in services research.*** Understanding service users' perspectives; understanding 'evidence-based processes' (as well as practices) as critical to evaluations of effectiveness of community-based interventions.

Applying for a Federal Grant (NIH)
(Most of these apply to other funding sources)

- If not an experienced researcher, 'apprentice' first
- Use NIH CRISP database; consult with Program Officers
- If 'PI ready'*, assemble a winning team (co-PIs, co-investigators, agency/institutional partners, expert consultants, etc.)
- If working with partner institutions, decide whether to subcontract (e.g., negotiate indirect costs, fringe, etc.) vs. 'buy out' time directly from consultants/co-investigators employed there
- Be VERY explicit and rigorous in Methods section
- Acknowledge and address ethical issues
- Find out from NIH Web site who is on Study Section..cite their work if appropriate!
- Hope (pray) for a priority score and %-ile ranking that allow re-submission. Wait for the 'pink sheets' and then get started….
- *Catch 22 for qualitative studies where credibility of the study depends upon the researcher's expertise (*must get research experience first, then apply*)