INTEGRATED DUAL DISORDER TREATMENT TEAM LEADER EXPERIENCES OF IMPLEMENTING THE INTEGRATED DUAL DISORDER TREATMENT MODEL: A GROUNDED THEORY

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INTEGRATED DUAL DISORDER TREATMENT TEAM LEADER EXPERIENCES OF IMPLEMENTING THE INTEGRATED DUAL DISORDER TREATMENT MODEL: A GROUNDED THEORY (280 pp.)

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The purpose of the current study was to generate a grounded theory of program implementation based on the experiences of 6 Integrated Dual Disorder Treatment (IDDT) Team Leaders from community-based mental health agencies in Ohio who were charged with implementing the IDDT model and were working with the Ohio Substance Abuse Mental Illness Coordinating Center of Excellence (SAMI CCOE). The primary research question that guided the current study was: How do 6 IDDT Team Leaders in Ohio describe their experiences of implementing the IDDT model?

The study was designed to address the lack of research on implementation of evidence-based practice. Although efficacy of evidence-based practice is well established in the literature, little is known about how to implement such practices, specifically from the viewpoint of front-line clinicians. Therefore, an understanding of how IDDT Team Leaders prepared for and actually implemented the model would increase the knowledge base on implementation of an evidence-based practice.

Three main themes emerged from and were grounded in the data and included: (a) learning to be an IDDT Team Leader, (b) learning about and embracing the IDDT model, and (c) implementing the IDDT model. Results of the current study suggest the

possibility of a model of implementation as a multi-dimensional process. This model builds on existing research on implementation at the macro level. It also builds on the limited research on implementation at the micro level while offering a new perspective on implementation. The framework of this model can be used to guide future research on implementation of the IDDT model from the perspective of front-line clinicians, specifically the IDDT Team Leader.

Additional findings that did not contribute to the main theme but were noteworthy are presented, and implications for counselor education, the field of counseling, and the Ohio Substance Abuse Coordinating Center of Excellence are discussed. Finally, limitations of the current study are presented, and recommendations for theory and research are provided.

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As I reflect on the process of completing this dissertation, I realize that it has been a journey that has taught me about the importance of knowledge, patience, and humility. I could not have completed it on my own, and I am thankful for the people in my life who have taken part in this journey with me.

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I am also thankful for the participants who willingly and openly shared their experiences with me. Their passion about both the model and clients allowed them to maintain their focus on a long-term goal. Each participant was an inspiration, and I appreciated the time that they were willing to give to me.

Finally, I dedicate this dissertation to my dad: I could never figure it out in your lifetime. I hope I will in mine.

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CHAPTER I

INTRODUCTION AND REVIEW OF THE LITERATURE

Introduction

Worldwide, mental illness affects approximately 450 million people (World Health Organization [WHO], 2005a). In the United States, mental illness is common and affects nearly every American family (New Freedom Commission on Mental Health, 2005). Numerous individuals diagnosed with mental illness are able to lead productive lives whereas others experience severe symptoms that are disabling and long term. When symptoms result in impaired functioning and personal stress that is recurring or sustained, the mental illness is classified as severe (Drake, Essock, et al., 2001). According to WHO (2001), between all diseases and injuries that result in disability (e.g., loss of productivity, premature mortality) worldwide among males and females 15-44 years of age, mental disorders are among the leading causes (see Table 1).

In the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision* ([DSM-IV-TR] American Psychiatric Association, 2000), substance related disorders are classified as mental disorders. Substance-related disorders are divided in two categories: substance use disorders (e.g., substance abuse and substance dependence) and substance-induced disorders (e.g., substance-induced psychotic disorder, substance-induced mood disorder). The prevalence of a substance use disorder among individuals also diagnosed with severe mental illness is alarming and creates a number of risk factors that negatively impact the treatment, course, and prognosis of the mental illness. The

Table 1

Ten Leading Causes of Disability Worldwide

1.	HIV/AIDS
2.	Unipolar depressive disorders
3.	Road traffic accidents
4.	Tuberculosis
5.	Alcohol use disorders
6.	Self-inflicted injuries
7.	Iron-deficiency anemia
8.	Schizophrenia
9.	Bipolar affective disorder
10.	Violence

Source: WHO, 2001

term co-occurring disorder is used to describe the simultaneous occurrence of at least one mental disorder with a diagnosis of at least one substance use disorder (Substance Abuse and Mental Heath Services Administration [SAMHSA], 2005).

The traditional approaches to treatment for individuals with co-occurring disorders are either sequential or parallel treatment (Mueser, Noordsy, Drake, & Fox, 2003). With sequential treatment, individuals are told that they cannot receive treatment for one disorder until the other is stable. With parallel treatment, the substance use disorder is treated in one setting while the severe mental illness is treated in another setting. Both disorders are neither addressed together nor integrated, often resulting in treatment failure (Drake, Mueser, Brunette, & McHugo, 2004; Drake & Wallach, 2000).

To address the lack of effective treatment, researchers have focused on integrated treatment approaches for co-occurring disorders, beginning in the 1980s (Drake, Mueser, et al., 2004; Drake & Wallach, 2000; Minkoff, 2000; Osher & Kofoed, 1989; Sciacca & Thompson, 1996). Integrated treatment involves comprehensive services that span from self-help interventions to intensive case management. Instead of treating each disorder in separate settings (i.e., parallel treatment), the individual with co-occurring disorders receives treatment in one facility by one clinician or a team of clinicians who are cross-trained in providing *both* mental health and substance use treatment (Drake, Mueser, et al., 2004; RachBeisel, Scott, & Dixon, 1999).

Numerous studies on integrated treatment have appeared in the literature over the past 20 years (e.g., Bachmann, Moggi, Hirsbrunner, Donati, & Brodbeck, 1997; Graeber, Moyers, Griffith, Guajardo, & Tonigan, 2003; Granholm, Anthenelli, Monteiro, Sevcik,

& Stoler, 2003; Greenfield, Weiss, & Tohen, 1995; Herman et al., 2000; Jerrell & Ridgely, 1999). For example, studies have focused on various aspects of treatment, from length of time in treatment (Brunette, Drake, Woods, & Hartnett, 2001; Drake, McHugo, & Noordsy, 1993; Drake & Mueser, 2000; Granholm et al., 2003) to robustness of program implementation (Jerrell & Ridgeley, 1999). Other studies have compared treatment programs (Graeber et al., 2003; Herman et al., 2000) and core components necessary for successful treatment (Drake, Bartels, Teague, Noordsy, & Clark, 1993; Mueser, Drake & Noordsy, 1998; Osher & Kofoed, 1989). In addition, some researchers have developed conceptualizations of effective programs (Anderson, 1997; Minkoff, 2005; Osher & Kofoed, 1989), and others have created models that have been adopted by various states (Mueser, Noordsy, et al., 2003; Sciacca, 1997a).

Findings from numerous studies indicate that integrated treatment, when applied consistently over a number of years, is effective (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998; Drake, Mueser, Clark, & Wallach., 1996; Mueser et al., 1998; RachBeisel et al., 1999). Many of the studies, however, are plagued by limitations (RachBeisel et al., 1999; Drake, Mueser, et al., 2004). For example, small sample sizes and the inclusion of limited populations (e.g., homeless, women) affect the generalizability of findings (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Persons & Silberschatz, 1998; RachBeisel et al., 1999). Despite these criticisms, Drake, Mueser, et al. (2004) stated that the *cumulative* evidence supports the effectiveness of integrated treatment.

The New Hampshire Dartmouth Psychiatric Research Center (PRC) was established in 1987 in response to the need to provide treatment to individuals with co-occurring disorders in New Hampshire (Teague, Mercer-McFadden, & Drake, 1989). The Integrated Dual Disorder Treatment (IDDT) model is based on the Dartmouth model created by the PRC. The IDDT model is a culmination of 20 years of study and has produced research indicating that integrated treatment is more effective than non-integrated treatment (Drake, Essock, et al., 2001). The IDDT model was adopted as one of six evidence-based practices by SAMHSA as part of the National Implementing Evidence-Based Practices Project (SAMHSA, 2002). The Project began in 2000 and focused on the dissemination of information on evidence-based practices, assistance with implementation, and monitoring adherence to each of the six original models (i.e., evidence-based practices): (a) co-occurring disorders: integrated dual disorders treatment (IDDT) model; (b) medication management approaches in psychiatry; (c) assertive community treatment; (d) family psychoeducation; (e) supported employment; and (f) illness management and recovery (SAMHSA, 2002).

Each evidence-based practice focuses on various aspects of treatment for individuals with mental illness. The co-occurring disorders: integrated dual diagnosis treatment (IDDT) model addresses treatment of both mental illness and substance use in one setting (SAMHSA, 2006a). The medication management approaches in psychiatry model was created in response to research findings that indicated that individuals with schizophrenia were either over- or under-medicated. The model focuses on the systematic use of medication in the treatment of schizophrenia (Power, 2003). The assertive

community treatment (ACT) model targets individuals with severe and persistent mental illness who have not responded to treatment in traditional settings (e.g., offices or clinics). An interdisciplinary team provides direct services 24 hours a day to individuals in the community with the goal of decreasing hospitalization (SAMHSA, 2006a).

The family psychoeducation model partners clinicians, family members or significant others, and the individual in treatment. With the use of education, problem solving and relationship building skills, and collaboration, clinicians assist the individual in developing or enhancing what may be a natural support system (SAMHSA, 2006a). The supported employment model was developed to assist individuals with mental illness in obtaining employment. Although the majority of individuals with mental illness state a desire to work, many need assistance in finding and maintaining employment (Power, 2003). Employment specialists, in collaboration with multidisciplinary treatment teams, provide a wide array of employment services and support for individuals from which to choose if they wish to pursue employment (SAMHSA, 2006a). The illness management and recovery model was designed to address personal empowerment. In weekly sessions over a three to six month period, clinicians work with individuals to assist them in managing mental illness (e.g., building social support, education about medication, coping skills) and maintaining stability while fostering self-care (Power, 2003).

William Torrey et al. (2001) explored the perspectives of clinicians, family advocates, administrators, and researchers on how to transfer research to practice. Findings indicated that implementation resource kits that included training experiences (e.g., videos), written material (e.g., workbooks), consultation opportunities (e.g., experts

that would be available for consultation with providers), and web-based resources (e.g., a website that would link providers with current research studies) would increase the likelihood of successfully implementing an evidence-based practice. In response to these findings, an implementation plan for evidence-based practice was formulated (W. C. Torrey et al., 2001) and the PRC was contracted to develop comprehensive implementation resource kits for five of the six evidence-based practices used in the project (G. McHugo, personal communication, June 28, 2006).

In 2000, mental health authorities in three states (i.e., Kansas, Ohio, and Indiana) made a commitment to implement the IDDT model (Biegel et al., 2003). The Ohio Substance Abuse Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE) was created in order to disseminate information, train staff at mental health agencies throughout the state, provide consultation, and monitor agency adherence to the model (Ohio SAMI CCOE, 2001b). The CCOE began working with nine community-based organizations that had agreed to pilot the model and had received funding from the Ohio Department of Mental Health (Biegel, Kola, & Ronis, 2007). As of June 2, 2006, the CCOE was working with over 60 community-based and public inpatient organizations (L.A. Kola & R.J. Ronis, personal communication, June 2, 2006).

Even though the Evidence-Based Practices Project was well thought out, not all researchers approve of its use. Various researchers have presented arguments against the use of evidence-based practice that range from the fulfillment of a political agenda to loss of individuality within evidence-based practice. However, the fundamental problem identified in the New Freedom Commission on Mental Health (2005) was that the current

mental health system is in disarray and needed to be transformed in order to make effective services available to individuals with mental illness. One of the recommendations made by the subcommittee was that evidence-based practice "ought to be among the choices offered to individuals who seek treatment for mental disorders with the expectation of moving toward recovery" (New Freedom Commission, 2005, p. 3).

Although researchers have identified what are considered to be evidence-based practices, they are not always adopted. It can take anywhere from 2 (Mueser & Drake, 2005) to 17 (Institute of Medicine, 1998) years for a new practice or finding to be used in the field. Rogers (1995) identified the process of transferring research to practice as *diffusion of an innovation* (p. 1), and a basic understanding of the stages of change as applied to a decision-making body (i.e., mental health agency) is helpful in considering the diffusion of an innovation.

Implementation

In order to successfully implement the IDDT model, it is necessary to have the support of numerous individuals within the mental health agency and, most importantly, the IDDT Team members. The IDDT Team Leader is in charge of implementing the model within the agency, and his or her character may be a factor in successful implementation. The Leader is in charge of a team of individuals, ranging from case managers to psychiatrists, who work together toward implementation. The IDDT Team Leader can be thought of as an innovator, which is a characteristic Kouzes and Posner (2002) attributed to effective leaders. The IDDT Team Leader is by all accounts a key component in successful implementation of the model.

Despite extensive planning at the national and state levels, numerous challenges create barriers to successful implementation. These challenges include but are not limited to the existence of two funding streams (i.e., mental health and substance abuse services systems) that vie for funding from the same governing bodies (Addiction Technology Transfer Center [ATTC], 2005b; Biegel et al., 2003), a lack of knowledgeable providers who are familiar with integrated treatment (ATTC, 2005b), agency staff turnover (which makes training and continuity of care difficult; Biegel et al., 2003; Boyle & Kroon, 2006), and fragmentation of delivery of services that create barriers to quality services and care (Azrin & Goldman, 2005; New Freedom Commission, 2005).

There is a gap in the literature regarding the actual implementation of evidence-based practices and the effectiveness of such practices when applied to treatment settings (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Goldman et al., 2001; Shumway & Sentell, 2004). Whereas efficacy is established in controlled research (i.e., randomized controlled trials) and focuses on internal validity, effectiveness addresses generalizability and appropriateness of treatment in clinical practice (Chambless & Hollon, 1998; Goldfried & Wolfe, 1998). Efficacy and effectiveness are equally important. In order for findings to be considered efficacious, at least two studies must be conducted by independent research teams (Chambless & Hollon, 1998). This eliminates the possibility that findings are due to faulty conclusions based on anomaly or chance. Effectiveness is vital to the successful transfer of research to practice (Chambless & Hollon) because it determines whether or not the research will work in a clinical setting. Although the need for efficacy is unquestionable, without

effectiveness findings cannot be generalized to the *real world*, thus compromising the integrity of the research (Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998). The few studies that do address implementation focus on the quality of implementation (i.e., adherence to the original model) and suggest that quality is a strong determinant of successful treatment (i.e., outcomes; W.C. Torrey et al., 2001). Overall, there is a lack of evidence to guide the implementation of evidence-based practice (Goldman et al., 2001). As Goldman et al. noted, "There is uncomfortable irony in moving forward to implement evidence-based practices in the absence of an evidence base to guide implementation practice" (p. 3).

Chambless and Hollon (1998) stated that at the effectiveness stage of research, quasi-experimental and nonexperimental designs are important in addressing questions of whether or not the treatment can work in actual practice. Furthermore, numerous authors emphasize the need to include qualitative methodology into research studies in order to expand the research base (Anthony, Rogers, & Farkas, 2003; Chambless & Hollon, 1998; Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998; Tanenbaum, 2003; Zlotnik & Galambos, 2004). Both quantitative and qualitative methodologies expand the research base and are equally important (Johnson & Onwuegbuzie, 2004). Whereas quantitative researchers focus on deduction or testing existing theories, qualitative researchers focus on induction (i.e., the generation of theory) and examining meaning and purpose (L. F. Campbell, 1996; Johnson & Onwuegbuzie, 2004; Tanenbaum, 2003).

Purpose

The purpose of the current study was to generate a grounded theory based on the experiences of 6 IDDT Team Leaders from community-based mental health agencies in Ohio who were charged with implementing the IDDT model and were working with the SAMI CCOE. By focusing on these individuals' perceptions of implementation, the researcher gained an understanding of the process of implementation along with ways to better implement the model, thereby addressing the need for research on implementation.

A grounded theory approach was used to generate a substantive theory about the process of implementation; an inductive process was therefore utilized. Each interview was audio taped, transcribed, coded, and analyzed. As a result of identifying themes about implementation from the interviews conducted, this research was intended to generate further discussion and consideration of effective IDDT model implementation.

Review of the Literature

The review of literature is organized into five sections. The first section addresses the need for treatment and includes the number of individuals diagnosed with mental illness in the general population, the prevalence of co-occurring disorders, past and present treatment, and the lack of effective treatment. In the second section, treatment models (adopted throughout the United States) designed to address co-occurring disorders are presented.

Section three of the literature review focuses on evidence-based practice and the Evidence-Based Practices Project, the formation of the Ohio Substance Abuse Mental Illness Coordinating Center of Excellence (SAMI CCOE), and existing research on EBP

implementation. Section four presents various viewpoints that challenge the use of evidence-based practices. Finally, section five addresses the transfer of research to practice and applying the stages of change to systems and diffusion of innovation. Section five also addresses the characteristics of leadership and the IDDT Team Leader, and presents strategies and suggestions for implementation. Challenges of implementation from sources outside the purview of the EBP Project are also discussed in this section.

The Need for Treatment

In the United States, 26.2% of the population 18 years of age and older meets criteria for a mental illness (NIMH, 2006a). This percentage translates to 1 in 4 adults or 57.7 million Americans. According to the *DSM-IV-TR* (APA, 2000),

> Each of the mental disorders [listed in the Manual] is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (p. xxi)

Numerous individuals diagnosed with a mental illness are able to manage their symptoms so that symptoms do not interfere with all areas of functioning (e.g., relationships, employment). However, many symptoms of mental illness are disabling and chronic and result in loss of quality of life, productivity, and, many times, suicide (NIMH, 2001). Of the 10 leading causes of disability in the United States (e.g., loss of

productivity, quality of life), mental illness is the leading cause (WHO, 2001). The economic impact of mental illness is staggering. According to the U. S. Department of Health and Human Services (U.S. DHHS, 2003), the United States spent over $99 billion for treatment of mental disorders in 1996. Indirect costs (e.g., premature death and loss of productivity) were estimated at $79 billion in 1990.

It is common for individuals diagnosed with a mental illness to have more than one mental illness diagnosis. The most prevalent co-occurring diagnosis is a substance use disorder (Drake, Essock, et al., 2001; Drake, Mueser, et al., 2004; Drake, Morse, Brunette, & Torrey, 2004). Unfortunately, substance use disorders significantly complicate the course, treatment, and prognosis of a severe mental illness diagnosis (Bartels, Drake, & Wallach, 1995; Drake, Teague, & Warren, 1990; Kessler, 1994; Osher & Kofoed, 1989).

The Prevalence of Co-Occurring Disorders

Individuals who are diagnosed with a mental illness are two times more likely to develop an alcohol related disorder and four times more likely to develop another substance use disorder (Regier et al., 1990). In his review of prevalence studies, Kessler (2004) found that substance use disorders are significantly related to mental illness. According to Minkoff (2000), "Comorbidity is an expectation, not an exception" (p. 252). However, due to the lack of training and experience in co-occurring disorders, mental health providers often are unable to detect a substance use diagnosis despite the high prevalence of substance use among those with severe mental illness (Drake, Morse, et al., 2004; Mueser, Drake, & Noordsy, 1998). According to R. M. Miller and Brown (1997),

because of the high prevalence of substance use among individuals who present with mental health problems, all mental health providers need to be "knowledgeable about substance abuse and competent to recognize and address these problems" (p. 1270).

The numbers and estimates of individuals with co-occurring disorders vary. For example, recent findings indicate that 5.6 million adults, ages 18 and older, are diagnosed with a co-occurring disorder (U. S. DHHS, 2006) According to SAMHSA's Co-Occurring Center for Excellence, "co-occurring substance abuse and mental disorders affect approximately 4.6 million people in the United States" (SAMHSA, 2006b). Within the Department of Veterans Affairs in 2001, 44% of 72,252 inpatients were diagnosed with co-occurring disorders (ATTC, 2005a). Regier et al. (1990) found that individuals diagnosed with a mental illness were more likely than the general population to have a problem with substances throughout their lifetime. Among those with a mental illness, 48% of individuals diagnosed with schizophrenia, and 56% of individuals diagnosed with bipolar disorder were likely to abuse substances. Another finding indicated that from 39% to 56% of individuals with a substance use disorder also had a mental illness disorder (Regier et al.). In comparison, the lifetime rate of substance abuse among individuals without a mental illness diagnosis is approximately 17% (Mueser, Drake, et al., 1998).

Kessler (1994) and Kessler et al. (1997) found similar patterns of comorbid mental and substance use disorders. Findings indicated that the majority of individuals in the United States diagnosed with alcohol abuse or dependence also had a lifetime history of a diagnosable mental disorder. Furthermore, the number of individuals with co-

occurring disorders in mental health and substance use treatment settings is higher than in other treatment settings (Regier et al., 1990). Drake (1990) stated that a conservative estimate of psychiatric clients with co-occurring disorders in treatment settings is approximately one-third. Recent estimates suggest that approximately 50% of individuals diagnosed with a severe mental illness use substances (Drake, Essock, et al., 2001; Ohio SAMI CCOE, 2005; RachBeisel et al., 1999; SAMHSA, 2002). However, given the likelihood that the majority of clients minimize or under report use, the numbers may be much higher (Drake et al., 1996; RachBeisel et al., 1999).

Substance use among individuals with a mental illness creates a number of risk factors including psychiatric hospitalization, suicide, noncompliance with medication, homelessness, and violence (Bartels et al., 1995; Drake et al., 1990; Drake, Mueser, et al., 2004c Drake & Wallach, 2000; Kessler, 1994, 2004; Kessler et al., 1996; Myrick & Brady, 2003; Osher & Kofoed, 1989; SAMHSA, 2005). Individuals with co-occurring disorders are also more likely to be victims of violence (Sells, Rowe, Fisk, & Davidson, 2003). A co-occurring disorder impacts the individual's social and work roles, leading to social isolation, loss of productivity, and mortality (Kessler, 1994). Substance use among individuals with a mental illness results in higher usage of services, notably emergency rooms and hospitalizations, and intensifies psychiatric symptoms (Drake et al., 1990; Mueser, Drake, et al., 1998). In one study, treatment costs for individuals with co-occurring disorders were 60% higher than the cost of psychiatric treatment for individuals who did not use substances (Dickey & Azeni, 1996). These factors not only impact the individual, but also impact family members both emotionally and financially (Mercer-

McFadden et al., 1998). The need for treatment is evident, yet because of multiple impediments (e.g., separate funding streams for mental health and substance use), effective treatment is lacking for the individual with a co-occurring disorder.

Past and Present Treatment of Co-Occurring Disorders

The traditional approaches to treatment for individuals with co-occurring disorders are sequential and parallel treatment. Within the first approach, sequential treatment, individuals are told that they cannot receive treatment for one disorder until the other is resolved or stabilized (Mueser et al., 1998). This results in conflicting and confusing messages to clients and limits compliance with treatment (Osher & Kofoed, 1989). With the second approach, parallel treatment, individuals are treated in different facilities by different clinicians. Clinicians treat individuals for one disorder while overlooking the other disorder. The responsibility of integrating the messages received from two facilities rests on the individual (Mueser et al., 1998). Unfortunately, individuals with co-occurring disorders do not fit into either treatment approach and become *system misfits*, resulting in treatment failure (Drake, Mueser, et al., 2004; Drake & Wallach, 2000; Minkoff & Drake, 1991).

Numerous states, including Ohio, have separate state governing bodies for mental health and substance use services. This leads to separate payment for substance use and mental illness treatment, two licensing boards and requirements for licensure, and differing treatment philosophies (Dickey & Azeni, 1996; Kessler et al., 1996; National Mental Health Information Center, 2005). As a result, clinicians lack training and experience in co-occurring disorders and are not cross-trained to work with an individual

with co-occurring disorders, leading to a separation of treatment approaches. Consequently, one of the diagnoses is considered primary, and the secondary diagnosis is not treated.

Numerous researchers recognized the need for integrated treatment and began focusing on integrated treatment approaches to co-occurring disorders in the early 1980s (e.g., Dickey & Azeni, 1996; Drake, Mueser, et al., 2004; Drake & Wallach, 2000; Minkoff, 2000; Mueser et al., 1998; Myrick & Brady, 2003; Osher & Kofoed, 1989; Sciacca & Thompson, 1996). Integrated treatment combines mental health and substance use treatment so that the individual with co-occurring disorders receives treatment in one facility by one clinician or a team of clinicians (Drake, Morse, et al., 2004; Minkoff, 2005; Osher & Kofoed, 1989). Instead of placing the burden of integration on the individual as seen in the parallel treatment approach, clinicians are cross-trained to work with both disorders and provide integrated treatment that focuses on both disorders. Furthermore, unlike sequential treatment, individuals are not told to stabilize one disorder before receiving treatment for the other. Treatment according to the integrated model, by comparison, is concurrent, ensuring consistency and reducing conflicting philosophies (Drake, Mueser, et al., 2004).

Mueser et al. (1998) reported that individuals (i.e., clients or patients) engaged in integrated treatment versus the traditional approaches of sequential and parallel treatment consistently demonstrated gradual progression towards reduced substance use over a period of several years. With integrated treatment, rates of remission reach 10-20% per year versus less than 5% with traditional approaches (Mueser et al.). Drake et al. (1996)

stated that "longitudinal data on dual disorders suggest that integrated treatment can lower hospitalization costs, reduce or eliminate substance use, and lead to other improvements in quality of life" (p. 48). Herman et al. (2000) stated that the use of integrated treatment in their study reduced the rate of alcohol use by 54% compared to standard hospital treatment 2 months post-discharge. According to SAMHSA (2005), integrated treatment "is the preferred model of treatment" (p. 44) and although further research is needed, it is thus far promising (Drake et al., 1998; Drake, Mueser, et al., 2004; Herman et al., 2000; Mueser et al., 1998).

The Lack of Effective Treatment for Co-Occurring Disorders

Unfortunately, mental health treatment is inadequate worldwide, and numerous countries spend a minute portion of their health budgets on mental health (WHO, 2005b). According to WHO (2005a), even though cost-effective treatments exist, disparity continues between mental and physical health. Within the United States, practices that have proven effective in research are usually not available in practice settings because the fragmented mental health delivery system results in numerous barriers (e.g., policies, administrative practices, lack of information technology; Institute of Medicine, 2001; New Freedom Commission on Mental Health, 2005; W.C. Torrey et al., 2002). There is also a large gap between the need for service and available funds (O'Brien et al., 2004; U.S. DHHS, 2003). The quality of care for individuals with co-occurring disorders in the United States falls below minimal standards (e.g., insufficient funding, failure of systems to meet the needs of individuals with co-occurring disorders) and results in inadequate care (Kessler et al., 2005; U.S. DHHS, 2003). Additional barriers such as clinical,

administrative, and organizational have impeded progress to incorporate integrated treatment within mental health agencies (Drake & Wallach, 2000).

Although numerous studies have shown that integrated treatment is effective for severe mental illness and substance use, only a small portion of this population receives any treatment at all (ATTC, 2005a; Drake et al., 1996; Drake, Morse, et al., 2004; Mueser et al., 1998; SAMHSA, 2003; U.S. DHHS, 2003). According to ATTC (2005a), only a small portion of individuals who receive Medicare or Medicaid monies receive treatment for co-occurring disorders. One study found that only 8.4% of individuals with co-occurring disorders received treatment for both disorders, whereas 49.2% received no treatment at all (U S. DHHS, 2006a).

Treatment Models

The lack of available and effective treatment for individuals diagnosed with severe mental illness has been the impetus for the creation of programs based on scientific research that target this population. Researchers and federal and state authorities have recognized the need to provide research-based treatment to individuals with severe mental illness. As a result, researchers have focused on specific aspects of treatment (e.g., Brunette et al., 2001; Drake, McHugo, et al., 1993; Mueser et al., 1998), conceptualizations of effective programs (e.g., Anderson, 1997; Minkoff, 2005), and the development of treatment models (Mueser, Noordsy, et al., 2003; Sciacca, 1997a).

A comprehensive treatment model provides structure and guidelines that can assist practitioners in implementing a specified practice. Blocher (1987) referred to a treatment model as a process model, or cognitive map, that guides practice and counselor

actions. Therapy goals, methods, and processes are identified within a treatment model (MacDonald & Webb, 2006). Such models focus on, and are evaluated by, client outcomes.

The states of New York and New Hampshire were the first to implement comprehensive models that addressed co-occurring disorders into treatment facilities (Sciacca, 1997a; Teague et al., 1989). Sciacca's (1997a) Mental Illness, Drug Addiction and Alcoholism model was implemented in New York, and the Dartmouth Model, created at the PRC, was implemented in New Hampshire. The IDDT model is based on the Dartmouth Model, and has been implemented in various treatment settings in Ohio, Indiana, and Kansas.

The Mental Illness, Drug Addiction, and Alcoholism Model

The Mental Illness, Drug Addiction, and Alcoholism (MIDAA) model, developed by Kathleen Sciacca in 1984, addresses the needs of individuals with co-occurring disorders (Sciacca, 1997a). Sciacca stated that the traditional confrontational approach in the addiction field was ineffective in the field of mental health. In response, she created a stage-wise model based on motivational interviewing, which was developed in the field of addiction by William R. Miller and Stephen Rollnick (2002). Motivational interviewing is a counseling style defined as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (W.R. Miller & Rollnick, 2002, p. 25). It is based on the premise that confrontation is ineffective and change is a choice that is determined by individuals (i.e., clients or patients).

Through the use of motivational interviewing, treatment is tailored to the individual's stage of change or readiness to change, and clinicians use strategies within each stage to enhance movement into the next stage. Although abstinence from substances is not a requirement for treatment, it is an overarching goal (Sciacca, 1997a). Clinicians address readiness to change within sessions and accept that individuals may not want to reduce substance use, consequently eliminating the requirement of abstinence that has served as a barrier to accessing and maintaining substance abuse treatment. The MIDAA model focuses on numerous aspects of treatment, including education, ongoing stabilization and rehabilitation, relapse prevention, comprehensive assessment, and client engagement (Sciacca & Thompson, 1996). A service manual is available to providers who wish to implement the program and includes the program structure, specific assessment tools, procedures, and other questionnaires and outlines (M. K. Miller, 1996). With the exception of a few flaws (e.g., lack of a glossary, weak organization), the manual has received favorable reviews (Francell & Zipple, 1995; M. K. Miller, 1996).

MIDAA was implemented in numerous treatment programs in the State of New York in 1985 (Sciacca, 1997a). A training site was developed to provide training seminars to practitioners. The training site was closed in 1990 due to budgetary considerations; however, the programs and groups that were formulated from the model continue to be an integral part of treatment in the State of New York (Sciacca, 1997a). MIDAA has also been implemented in two counties in Michigan (Sciacca & Thompson, 1996; Sciacca, 1997b) and Tennessee (Sciacca, 1998). Although Sciacca (1997b) made the claim that "outcomes in all programs demonstrate that consumers who have never

participated in substance abuse treatment, and/or have avoided mental health treatment, can engage in dual diagnosis treatment in a meaningful way" (p. 5), she did not define *meaningful*. Furthermore, there is a lack of research on the effectiveness of this model.

The Dartmouth Model

In the 1980s, state authorities in New Hampshire began to recognize the prevalence of individuals with co-occurring disorders in the state (Teague et al., 1989). These individuals comprised "approximately 30-40 percent of the outpatient and 60-80 percent of the inpatient populations among the chronically mentally ill in New Hampshire" (Drake et al., 1990, p. 35). In response to the need for effective treatment, a plan was developed for the provision of integrated services between the New Hampshire Division of Mental Health and Development Services (DMHDS) and the New Hampshire Office of Alcohol and Drug Abuse Prevention (OADAP) with support from the Robert Wood Johnson Foundation (Drake, Antosca, Noordsy, Bartels, & Osher, 1991; Teague et al., 1989). In 1987, a contract was drawn to create the PRC to conduct clinical research that would guide practice throughout the mental health and addiction systems in New Hampshire (Mercer-McFadden et al., 1998; Teague et al., 1989). Staff from DMHDS, OADAP, and the PRC worked together to train clinicians, create a new service subsystem to address the needs of individuals with co-occurring disorders, apply for outside funding, and evaluate the system.

Within the original plan of integrated treatment, three components were identified: (a) integrated services; (b) continuous practitioner training on co-occurring disorders; and (c) coordination, planning, and development. The first component,

integrated services, consisted of continuous treatment teams that would individualize service plans, evaluate individuals using standardized instruments, ensure continuity of care, and enlist individuals (i.e., clients) as outreach collaborators (Drake et al., 1990; Teague et al., 1989). The treatment teams consisted of one full-time nurse, three clinicians or case managers, and a part-time psychiatrist. The teams provided services to clients in the community (e.g., medication, skills training), instead of asking clients to come into the agency (Teague et al.). Another component of integrated services included short-term residential treatment facilities for clients who were in need of more intensive services. Treatment consisted of education and non-confrontational techniques focused on engaging clients in treatment instead of insisting on abstinence.

The second component focused on continuous practitioner training in co-occurring disorders. Initially, practitioners were engaged in an intensive co-occurring disorders workshop for one week. Practitioners received an overview of the separate treatment systems of mental illness and substance abuse, along with more intensive training on integrating the two systems. Day-long workshops were provided to update practitioners on new materials and to provide a forum for state-wide providers to share experiences.

The third component consisted of coordination, development, and planning that would reduce the separation between the funding streams and service system authorities created to treat the two disorders. The overall goal was to create collaboration between staff from the New Hampshire Division of Mental Health and Development Services and the New Hampshire Office of Alcohol and Drug Abuse Prevention, along with

consumers, family members, clinical staff, and expert consultants throughout the state (Teague et al., 1989).

Working within four stages of treatment continues to be an integral part of training in the Dartmouth model (Drake et al., 1990). Osher and Kofoed (1989), who first defined the stages of treatment, stated that individuals (i.e., clients or patients) are in different stages of treatment, and treatment goals should reflect the identified stage. Each stage is behaviorally defined according to clients' use of substances and relationship with the treatment provider (i.e., based on a continuum of no contact with a treatment provider to consistent contact with a treatment provider), which allows clinicians to develop strategies that are specific to clients' stage of treatment (Mueser et al., 1998). Furthermore, specific interventions within each stage are identified to enhance movement through the stages of treatment.

The stages of treatment are closely related to the five stages of change defined within the Transtheoretical Model created by Prochaska, Norcross, and DiClemente (1992; see Table 2). Although the stages of treatment and the stages of change overlap, there is a difference between the two concepts. The stages of treatment were developed for treatment of individuals with co-occurring disorders and focus on changes that occur within the context of the helping relationship (Mueser et al., 1998). The stages of change are not based on treatment and treatment providers; rather, they focus on the client's internal motivational state. However, the goals of treatment within the stages of treatment and stages of change are the same: both are client-centered, focusing on being with

Table 2

Stages of Treatment and Stages of Change

Stages of Treatment	Stages of Change
Osher and Kofoed (1989)	Prochaska, Norcross, and DiClemente (1992)
Engagement	Precontemplation
Persuasion	Contemplation
	Preparation
Active Treatment	Action
Relapse Prevention	Maintenance

clients in a non-judgmental, non-confrontational manner, and meeting clients where they are at the moment (Mueser, Noordsy, et al., 2003).

The primary goal of the engagement stage of treatment is to establish trust and develop rapport between prospective clients and representatives of the agency (Drake et al., 1990). In this stage, clients have not made contact with case managers or have had irregular contact with case managers and are not ready to discuss abstinence. Instead, clients are focused on basic needs (e.g., housing, food). Linkage to supports in the community, outreach, and psychiatric stabilization are the focus of clinical interventions. Overall, clinicians need to focus on convincing clients that the agency can provide numerous needed services and working with the agency can be beneficial (Drake et al., 1990; Osher & Kofoed, 1989).

In the persuasion stage of treatment, clients are in regular contact with case managers or counselors. In early persuasion, clients are not ready to address the impact of substance use on their lives. In the latter part of persuasion (i.e., late persuasion), clients continue to have regular contact with case managers or counselors and have begun to reduce substance use. The clinician's goal throughout this stage is to educate clients about mental illness symptoms (Osher & Kofoed, 1989) along with educating clients about the legal and social consequences of substance use (Drake et al., 1990). By applying a motivational interviewing style (W.R. Miller & Rollnick, 2002), clinicians can enhance movement through this stage. For example, identifying clients' goals and developing discrepancies between established goals and behaviors that sabotage such goals is one effective way to help clients alleviate ambivalence. Other effective ways to assist clients experiencing ambivalence is by providing group interventions, family education, safe housing, and proper medication management (Mueser et al., 1998).

In the active treatment stage, clinicians focus on assisting clients in developing strategies to achieve abstinence (Osher & Kofoed, 1989). Clients are motivated to pursue abstinence in this stage and have reduced the use of substances for at least one month but less than six months (Mueser, Noordsy, et al., 2003). Within this stage, individual counseling focuses on changing behavior and developing healthy coping strategies. Group work focuses on developing social skills in order to assist clients in dealing with high risk situations. Clients are also introduced to self-help groups such as Alcoholics Anonymous or Dual Recovery Anonymous.

When clients are in the relapse prevention stage of treatment, they have maintained a period of abstinence or have not had problems for longer than six months as a result of use (Mueser, Noordsy, et al., 2003). Clinicians are strongly encouraged not to end treatment at this stage. Time-unlimited services are paramount in the Dartmouth model if clients are to achieve success (Brunette et al., 2001; Drake, McHugo et al., 1993; Mueser, Noordsy, et al., 2003). Clients are taught about relapses or slips and are encouraged to create a relapse prevention plan in order to get back on track once this happens (Drake et al., 1990). Supported employment is introduced at this stage as is independent housing (Mueser et al., 1998).

The Integrated Dual Disorder Treatment Model

The IDDT model, based on the original Dartmouth model, is a culmination of approximately 20 years of research and incorporates both psychoeducational interventions and biopsychosocial treatments (Mueser, Noordsy, et al., 2003). Research has generated consistently positive client outcomes for this model (Biegel et al., 2003; Drake, Essock, et al., 2001). The IDDT model defines one core value and seven core components, or dimensions, that work together to create treatment that produces favorable client outcomes (Mueser, Noordsy, et al., 2003). These are presented in Table 3.

The core value of the IDDT model is shared decision making, and there are seven core components, or dimensions, of this value (Mueser, Noordsy, et al., 2003). The seven core components have been identified as vital to successful integrated treatment, and if any of these components is missing, the program's effectiveness is jeopardized (Drake,

Table 3

Core Value of the IDDT Model and the Seven Core Components

Core Value: Shared Decision-Making
Seven Core Components of Shared Decision-Making
1. Motivation-based treatment
2. Assertiveness
3. Multiple therapeutic modalities
4. Reduction of negative consequences (i.e., harm reduction)
5. Comprehensiveness
6. Integration of services
7. Time-unlimited services

Source: Mueser, Noordsy, et al., 2003

Essock, et al., 2001; Mueser, Noordsy, et al., 2003). Shared decision making implies that clients, along with significant others, have a primary voice in treatment. Clinicians educate clients in order to raise awareness of or increase insight into mental illness symptoms and increase clients' ability to manage the illness. Significant others are used as supports for clients and assist clients in decision making when needed. Clients are involved in treatment planning and establish their own goals of treatment.

The first core component of shared decision-making is motivation-based treatment, or motivational interviewing (W.R. Miller & Rollnick, 2002), which is based on the premise that clients present with various levels of motivation in regard to substance use. Clinicians accept clients' level of motivation to change. For example,

many clients are not ready to discuss their substance use whereas others have been abstinent for long periods of time. Stages of treatment (Osher & Kofoed, 1989) used in conjunction with motivational interviewing, are an integral part of treatment. Motivational interviewing consists of three key components and four general principles (W.R. Miller & Rollnick, 2002) presented in Table 4. Overall, motivational interviewing is a counseling style that focuses on being with clients in their journey of change. The ultimate decision for change is made by clients, and the clinician's role is to enhance intrinsic motivation for change.

Assertiveness is another core component that focuses on engaging clients in treatment (Mueser, Noordsy, et al., 2003). Case managers go into the community instead of waiting for clients to arrive at the agency. A majority of case managers' time is spent in the field, that is, in clients' environments, working with clients to provide practical help with basic needs. The overall goal is to establish rapport and build clients' trust. By understanding clients' environments, case managers are better equipped to assist clients. The client-to-clinician ratio is low in order to accommodate clients' needs. Clinicians can monitor medication compliance and can watch clients closely for signs of deterioration that may lead to hospitalization.

Within the core component of multiple therapeutic modalities in the IDDT model, three types of counseling are made available to clients: (a) group counseling, (b) individual counseling, and (c) family counseling. The various types of groups offered include educational, self-help, social skills training, and stage-wise groups. The advantages of group treatment are numerous and include learning from other members

Table 4

Key Components and General Principles of Motivational Interviewing

Key Components
1. Collaboration (e.g., the development of a partnership with clients)
2. Evocation (e.g., evoking clients' internal motivation for change)
3. Autonomy (e.g., clients choose what changes, if any, are important)
General Principles
1. Expressing empathy, based on the Rogerian concepts of accurate empathy and reflective listening
2. Developing discrepancy between clients' goals and the behaviors that interfere with attainment of goals
3. Clinicians roll *with resistance* by avoiding argumentation, offering new perspectives without demanding that clients change, and maintaining an awareness of the need to change
4. Supporting self-efficacy by maintaining hope and the belief that clients have the ability to make changes

Source: W. R. Miller & Rollnick, 2002

how to cope with co-occurring disorders, allowing clients to realize that they are not alone, and learning the importance of support. Within individual counseling, clinicians base their approach on motivational interviewing and cognitive-behavioral counseling.

Through the use of motivational interviewing, clinicians focus on raising awareness of use and assisting the client in developing motivation to change. With cognitive-behavioral therapy, the clinician uses learning-based interventions to assist the client in developing and achieving goals. By engaging in family therapy, what might be a

natural support is reinforced as family members or significant others learn about both illnesses and how to support clients.

By including what is referred to as harm reduction (the fourth component of shared decision-making), clinicians do not approach clients with the expectation that clients will necessarily abstain from substance use (Mueser, Noordsy, et al., 2003). The philosophy of harm reduction is that of reducing the negative consequences of and harm caused by behaviors that carry risk (e.g., alcohol or drug use; Wikipedia, n.d.; Marlatt, n.d.). Harm reduction efforts include designated driver campaigns, safe-sex programs, needle exchange programs, and heroin maintenance programs. The choice of whether or not to engage in these efforts is left to the individual (Marlatt, n.d.). However, harm reduction is controversial and viewed negatively by federal agencies in the United States; therefore, it is not widely supported (Drucker, 2005). According to Drucker, conservative politicians have undermined harm reduction efforts for two decades, and efforts to eradicate harm reduction have worsened over the past few years under the George H.W. Bush administration. For example, in 2003, "the US Department of Health and Human Services began 'special reviews' [to decrease funding] of all current research grants that involved harm reduction, sex and drugs, and continues its ban on funding of needle exchange" (Drucker, 2005, Abstract).

Although the use of harm reduction has proven effective in numerous studies, a significant portion of the public and many institutions currently focus on abstinence as the only alternative (Drucker, 2005; Majoor & Rivera, 2003; Marlatt & Witkiewitz, 2002). Rogers (2002) stated that "interpersonal channels are more effective [than mass

media channels] in informing and changing attitudes toward a new idea, and thus in influencing the decision to adopt or reject a new idea" (p. 990). As a result of political controversy, the use of harm reduction is neither widely adopted nor openly acknowledged by treatment programs. However, harm reduction is an integral part of the IDDT model because many clients do not have the motivation to stop or even reduce use. Furthermore, harm reduction is based on the same principles as motivational interviewing (Marlatt & Witkiewitz, 2002; Minkoff, 2000). For example, although abstinence is encouraged, clinicians recognize that clients may not have a goal of abstinence and meet clients where they are in terms of their readiness to change. If clinicians approached clients with the expectation that abstinence was the only alternative, then the engagement process would be hindered. The goal of clinicians is thus to protect clients from harm associated with use while enhancing their motivation to change.

Comprehensive services constitute another core component in the IDDT model and include social skills training, supported employment, family psychoeducation, pharmacological treatment, training clients in illness management, assertive community treatment (i.e., assertiveness), and residential services. By providing an array of services, clinicians are able to assist clients with a variety of needs. The main focus of comprehensive services is to provide clients with the opportunity to make lifestyle changes in order to reduce or abstain from substances.

The core component of integrated services includes the provision of treatment for both substance use and mental illness. The clinician, or team of clinicians, is trained in working with both disorders and is responsible for integrating both into one treatment.

Other aspects of integrated treatment include integrated assessment, crisis planning, and treatment planning. By incorporating an integrated assessment into a program, clinicians are able to gain an understanding of both illnesses and how they interact with each other. Information gathered from a thorough assessment is helpful in understanding clients' reason(s) for use along with the interaction between use and mental illness (Mueser, Noordsy, et al., 2003). Crisis planning is important due to the prevalence of relapse and rehospitalization. Important elements of a crisis plan include signs of relapse for both disorders, the interaction between both disorders, and identified steps that clients need to take should a crisis occur (Mueser, Noordsy, et al.). Treatment planning focuses on both disorders and their interactions and uses information extracted from the comprehensive assessment and crisis plan. This allows clinicians to tailor treatment to clients' needs.

Clients with co-occurring disorders do not achieve recovery quickly and rates of remission are 10-20% per year (Drake et al., 1998; Mueser et al., 1998). Therefore, the final component of shared decision-making, time-unlimited services, is important to the success of a program. Research suggests that short-term programs do not produce the favorable results seen in programs that span long periods of time (Brunette et al., 2001; Drake, McHugo, et al., 1993; Mueser, Noordsy, et al., 2003). Clients need to make major life changes in order to learn to abstain from use, and most of these changes occur over months or years.

In addition to the core value and seven core components outlined above, the IDDT model includes organizational and treatment factors that require routine monitoring in order to adhere to fidelity to the original model. For example, an organization needs to

develop structural supports such as establishing procedures, selecting and recruiting practitioners, and inservice training that are conducive to the implementation of an evidence-based practice (Fixsen et al., 2005). The structural supports include administrative staff able to focus on desired outcomes, and systems interventions designed to ensure the availability of the human, financial, and organizational resources necessary to support both practitioners and implementation. In sum, clinicians are not the sole proprietor of successful implementation. The success of implementation is dependent upon numerous individuals and governing bodies.

Evidence-Based Practice

Over the past 8 years, more monies have been directed toward research focusing on establishing effective treatment for severe mental illness (National Mental Health Information Center, 2005). The result has been the recognition of six existing practices adopted as evidence-based practices (Ohio SAMI CCOE, 2005b). The practices focus on providing effective services to individuals diagnosed with severe mental illness and assisting these individuals in developing and achieving an individualized recovery process (Gill & Pratt, 2005; Persons & Silberschatz, 1998; SAMHSA, 2002). Overall, the practices emphasize empowering individuals.

According to Drake, Latimer, Leff, McHugo, and Burns (2004), the difference between evidence-based and best practice is well defined. Whereas best practice is based on clinical opinion and experience combined with a review of the research literature, evidence-based practice relies on treatment that has withstood randomized controlled trials, has been replicated, and has generated positive client outcomes (Drake, 2005;

Drake, Latimer, et al., 2004; West Institute, 2005). Randomized controlled trials (RCTs) are equated with efficacy and are considered to be the *gold standard* in psychotherapy research (Chambless & Hollon, 1998; Persons & Silberschatz, 1998). Although numerous treatments are available for different disorders, many studies are not generalizable because various factors (e.g., patient homogeneity) compromise external validity (New Freedom Commission, 2005). An intervention is considered to be a model program or an evidence-based practice when multiple randomized controlled trials are performed on an intervention by various researchers, outcomes are consistently favorable, and the study is generalizable (Drake, Latimer, et al., 2004; Mueser, Torrey, Lynde, Singer, & Drake, 2003). When reliability and validity are high, client outcomes can then be attributed to the intervention (Anthony, Rogers, & Farkas, 2003). Evidence-based practices are model programs that have produced consistent positive client outcomes through extensive research and are generalizable to various settings. They contribute to quality improvement (e.g., through the provision of a well-established, cost-effective service) and promote accountability (e.g., through fidelity measures that determine adherence to the evidence-based practice; Goldman et al., 2001; New Freedom Commission, 2005).

The Evidence-Based Practices Project

In an effort to bridge the gap between practice and research, a national demonstration project called the Evidence-Based Practices (EBP) Project was created in 2000 (Drake, 2006; Drake, Goldman, et al., 2001). Six evidence-based practices that focused on severe mental illness were identified by a consensus panel sponsored by the Robert Wood Johnson Foundation (Drake, 2006): (a) illness management and recovery;

(b) medication management approaches in psychiatry; (c) assertive community treatment; (d) family psychoeducation; (e) supported employment; and (f) co-occurring disorders: integrated dual disorders treatment.

State mental health authorities (i.e., funders) from eight states (i.e., Indiana, Kansas, Maryland, New Hampshire, New York, Ohio, Oregon, and Vermont) made a commitment to pilot the implementation of at least one of the practices in routine mental health care (Ohio SAMI CCOE, 2003), and 53 sites across the eight states implemented at least one of the six evidence-based practices (McHugo et al., 2007). Of the six evidence-based practices identified by the consensus panel, medication management approaches in psychiatry was not adopted by any of the eight states.

The focus of this project was to demonstrate that faithful implementation of an evidence-based practice could occur with the use of training materials (i.e., implementation resource kits) and standardized guidelines (Drake, Goldman, et al., 2001; SAMHSA, 2002). The project was initiated by SAMHSA as well as the Robert Wood Johnson Foundation, the nation's largest philanthropy that supports the improvement of health and healthcare. It was later endorsed and funded by other organizations at the local, public, national, and private levels (e.g., Johnson and Johnson Charitable Trust; SAMI CCOE, 2003; West Institute at New Hampshire-Dartmouth PRC, 2005).

The EBP project originally consisted of three phases, which were to take place over a 5- to 6-year period (i.e., 2000-2006). Phase One was to occur between the fall of 2000 to the spring of 2002, Phase Two was to occur between the summer of 2002 to the summer of 2004, and Phase Three was to occur between the summer of 2004 and the

summer of 2005/2006 (Mueser, Torrey, et al., 2003). The EBP project was devoted to the development of the implementation resource kits, field testing the kits, data collection and analysis, and modification and dissemination of the kits throughout the United States (Mueser, Torrey, et al., 2003; SAMHSA, 2002).

In Phase One of the EBP Project, implementation resource kits were developed to create guidelines for agencies and practitioners to follow during implementation (Mueser, Torrey, et al., 2003; West Institute at NH-Dartmouth PRC, 2005). Various researchers have used treatment manuals in randomized controlled trials because the use of manuals strengthens reliability and provider adherence to a model (Corrigan et al., 2001; Project Match Research Group, 1996). Manuals provide guidelines for treatment and clearly outline strategies and techniques necessary to replicate a treatment model (Chambless & Hollon, 1998). The New Hampshire-Dartmouth PRC was contracted to develop and oversee five of the six practices: (a) supported employment, (b) integrated dual disorder treatment, (c) assertive community treatment, (d) family psychoeducation, and (e) illness management and recovery (G. McHugo, personal communication, June 28, 2006).

Various stakeholders (i.e., clinicians, family members, consumers, program leaders, mental health authorities, and clinical supervisors) provided input into the development of the implementation resource kits. By involving all of the major participants or stakeholders prior to and during implementation, successful implementation is more likely to occur (Drake, Morse, et al., 2004; Fixsen et al., 2005; Humphries, 2003; Macaulay & Nutting, 2006; SAMHSA, 2002; W.C. Torrey et al., 2002). According to Macaulay and Nutting (2006), the gap between research and practice

could potentially be narrowed by developing an equal partnership among clients, clinicians, and researchers throughout the research process (e.g., participatory research). The use of a methodology that focuses on developing a partnership between stakeholders allows for individual voices (i.e., those of clients) to be heard and broadens and builds research credibility by incorporating the experiences and strengths of service users (Humphries, 2003; Truman & Raine, 2001). These stakeholders are committed to implementation and focus on increased awareness at the local and state level, planning, monitoring, moving the program forward, and enacting and sustaining the phases of implementation (W.C. Torrey et al., 2002).

Each implementation resource kit describes an evidence-based practice and includes strategies and tips for implementation that involve all stakeholders, training and educational materials, recommendations for implementation, outcome measures, and a fidelity scale to ensure that the agency and individual practitioners are adhering to the original model (SAMHSA, 2002). The fidelity scale not only focuses on adherence to the original model, it also focuses on process (e.g., weekly supervision, training), resulting in accountability in that the agency and clinicians are providing treatment based on the original model. During Phase One of the EBP Project, a plan for training and consultation was also developed to facilitate the transfer of research into clinical practice (SAMHSA, 2002). This phase ended in 2002 (G. McHugo, personal communication, June 28, 2006).

Phase Two of the Evidence-Based Practice Project was focused on field testing the resource kits and analyzing data obtained during this phase (G. McHugo, personal communication, June 28, 2006; SAMHSA, 2002). State mental health authorities in the

State of Ohio agreed to field test two implementation resource kits and their associated practices: IDDT and illness management and recovery (Ohio SAMI CCOE, 2003). Within the State of Ohio, nine pilot sites received funding from the Ohio Department of Mental Health to implement IDDT (Biegel, Kola & Ronis, 2007).

In this second phase of the EBP Project, centers were created in each state to assist with implementation. Through funding from the Ohio Department of Mental Health (ODMH), the Ohio SAMI CCOE was created in 2000 to facilitate the implementation of IDDT and demonstrate that effective implementation can occur (Biegel et al., 2003; Ohio SAMI CCOE, 2005a). In 2002, the Ohio SAMI CCOE began providing support to agencies in the State of Ohio (Ohio SAMI CCOE, 2007). The CCOE worked with the original nine pilot sites established in the state, along with other agencies in Ohio that were interested in implementing IDDT (Wieder & Kruszynski, 2007). According to G. McHugo (personal communication, June 28, 2006), Phase Two of the EBP Project was completed in 2005.

Phase Three was intended to be a national rollout of the evidence-based practices where the implementation resource kits were to be modified according to information obtained in Phase Two (SAMHSA, 2002). The practices were to be disseminated to agencies throughout the United States, and guidelines for training and consultation were to be drawn from information gathered in Phase Two (SAMHSA, 2002). Unfortunately, Phase Three never occurred due to lack of funding and what G. McHugo (personal communication June 28, 2006) phrased *other considerations* at SAMHSA; however, the

PRC will continue to analyze the implementation process data with funding from other sources.

The Ohio Substance Abuse Mental Illness Coordinating Center of Excellence

The Ohio Substance Abuse Mental Illness Coordinating Center of Excellence (SAMI CCOE) was created in 2000 and began providing services in 2002. Even though Phase Three never occurred at the national level, the SAMI CCOE continues to assist programs in the State of Ohio with implementation of the IDDT model. The SAMI CCOE is funded by the Ohio Department of Mental Health and is a collaboration of the School of Medicine and the School of Applied Social Sciences at Case Western Reserve University (Biegel et al., 2003; Ohio SAMI CCOE, 2001b). The SAMI CCOE also receives funding from the Ohio Department of Alcohol and Drug Addiction Services, consultation and training fees from out-of-state agencies, private foundations, and grant projects (Ronis, 2004). The SAMI CCOE is equivalent to the change agent described by Rogers (1995); that is, a group of persons who influence others in the innovation-decision process, focus on the adoption of new ideas, and continuously reinforce the decision to adopt an innovation.

The SAMI CCOE assists programs with implementation of the IDDT model by providing clinical training and supervision and offering consultation to administrators and IDDT team members. The SAMI CCOE also distributes research about integrated treatment, and conducts research that provides a continuous quality improvement feedback loop. The CCOE works with any mental health agency in the State of Ohio that is interested in implementing the model. Furthermore, the CCOE continually builds

relationships between and among all stakeholders (e.g., state and local mental health authorities, clients) in order to establish a network of individuals committed to implementation of the IDDT model.

In order to successfully implement the IDDT model, clinicians need training in numerous areas, including assessment and treatment of *both* mental illness and substance use, motivational interviewing, cognitive-behavioral therapy, and stage-wise treatment (Biegel et al., 2003). The Ohio SAMI CCOE provides workshops and training activities throughout the year based on the assessed needs of IDDT team members at agencies throughout the state. A conference held each year in September or October was established to provide training workshops and to allow providers an opportunity to network with other providers throughout the state.

The SAMI CCOE is available for consultation to mental health treatment agencies and is a link between providers and experts in the field of co-occurring disorders. During the first year of implementation at an agency, SAMI CCOE staff provides more intensive training (Boyle & Kroon, 2006) and is available throughout the implementation process. The SAMI CCOE also provides administrative consultation to agency administrators, hospital administrators, and county board administrators who are interested in implementing IDDT (Biegel et al., 2003).

The Ohio SAMI CCOE team is comprised of individuals who have been part of treatment programs that have closely adhered to and maintained fidelity to the IDDT model. Linking individuals in newer programs with individuals in well-established, high-fidelity programs has created a peer network for ongoing relationships between agencies

(Biegel et al., 2003). For example, programs that have been in existence for a longer period of time and have strong IDDT programs in place can provide advice, strategies, and support to newer programs that are just starting (SAMHSA, 2003).

The SAMI CCOE also coordinates regional (e.g., Northeast Ohio, Central Ohio) meetings on a periodic basis. The meetings provide opportunities for providers in these regions to network with other providers, learn about implementation at other agencies, and share valuable information that eases the implementation process (e.g., staging tools).

The SAMI CCOE is committed to distributing the most recent research on evidence-based practices (Biegel et al., 2003). Two methods of doing so are through the SAMI CCOE website (http://www.ohiosamiccoe.cwru.edu/about/aboutus.html) and a semi-annual newsletter entitled *SAMI Matters*. The website, created in 2001, offers a comprehensive overview of the model and the SAMI CCOE. A message board is available to providers throughout the state to post questions about program implementation and receive feedback from both SAMI CCOE staff and other program providers. The website also offers a program locator so that providers can find other treatment facilities implementing IDDT throughout Ohio.

The SAMI CCOE provides a continuous quality improvement feedback loop by monitoring each program's fidelity to the model and consumer outcomes and giving feedback to providers on strategies to increase adherence to the model. The SAMI CCOE adapted the IDDT fidelity scale, developed by the National Evidence-Based Practice Implementation Project, to create an IDDT Fidelity Scale Rating Sheet for use in Ohio (Appendix A). The scale ensures adherence to the IDDT model, allowing for replication

(Mueser et al., 2003). It assesses 12 organizational characteristics that determine an organization's (e.g., treatment facility's) commitment to the model (Ohio SAMI CCOE, 2001a), and 13 treatment characteristics that focus on biopsychosocial treatment (Mueser, Noordsy, et al., 2003; Ohio SAMI CCOE, 2001). These organizational and treatment characteristics are presented in Table 5 (see Appendix B for a definition of items). The combined 25 characteristics are called fidelity domains or core components of the model (SAMI CCOE, 2006). The IDDT Fidelity Scale Rating Sheet uses a Likert scale from 1 (*no evidence of fidelity*) to 5 (*full adherence to fidelity*). The SAMI CCOE uses the rating scale to determine a program's adherence to the original model. An explanation of each item, along with guidelines to rate each item, is included in the IDDT fidelity scale rating sheet.

In order to successfully implement the IDDT model, a commitment from all stakeholders (e.g., clinicians, supervisors) and all aspects of an organization (e.g., the philosophy of the organization, performance improvement) are required. If the organizational characteristics are not in place, program longevity is compromised (Mueser, Noordsy, et al., 2003). For example, if the philosophy of the IDDT model is not woven into the fabric of the organization, administration will not back the intensive efforts necessary to implement the model (e.g., on-going training and supervision). Another way to ensure successful implementation is to provide consistent feedback to practitioners about the process of implementation and the outcomes derived from this process (Fixsen et al, 2005; SAMHSA, 2002). The importance of feedback is incorporated into process and outcome monitoring, along with the involvement of the

Table 5

IDDT Fidelity Scale

Twelve Organizational Characteristics

1. Program philosophy
2. Identification and eligibility of clients
3. Penetration (i.e., the number of clients who are eligible for treatment versus the number of clients actually served by the program)
4. Comprehensive assessment
5. Treatment planning
6. Treatment that is consistent with IDDT and is reflected in the treatment plan
7. Training of staff
8. Weekly supervision of staff
9. Monitoring of the process of implementation
10. Outcome monitoring
11. The program is monitored by the agency's Quality Implementation Committee
12. Client choice

Thirteen Treatment Characteristics

1a. A multidisciplinary team that works with clients to assist clients in achieving goals

1b. A substance abuse specialist who works within the multidisciplinary team

2. Stage-wise interventions based on the stages of treatment
3. Access to comprehensive services
4. Time unlimited services
5. Outreach to clients
6. Use of motivational interventions
7. All clinicians have a basic understanding of substance abuse principles

(*table continues*)

Table 5 (continued)

IDDT Fidelity Scale

8.	Group dual disorder treatment
9.	Family dual disorder treatment
10.	Self-help group linkage
11.	Pharmacological treatment consistent with the model
12.	Interventions to promote health/Interventions to reduce negative consequences (e.g., safe housing, needle-exchange programs)
13.	Secondary interventions for treatment non-responders (e.g., introducing medication such as disulfiram to reduce cravings)

Source: Mueser, Noordsy et al., 2003

agency's Quality Improvement Committee. By providing consistent feedback to clinicians, organizational performance can improve (SAMHSA, 2002), and clinicians can objectively gauge progress of client outcomes and strategize to improve the quality of treatment.

The SAMI CCOE coordinates with treatment facility staff an external team visit to the treatment facility once a year. The external team uses the IDDT Fidelity Scale Rating Sheet to monitor fidelity to the model and follows an established protocol to rate each program. The external team consists of representatives from other IDDT programs, the SAMI CCOE, the Ohio Department of Mental Health, and the Ohio Department of Alcohol and Drug Addiction Services (Biegel et al., 2003). Ratings are based on interviews with program leaders, senior staff, clinicians, clients and/or families, written

materials (e.g., brochures), and clients' charts. The SAMI CCOE provides feedback to programs based on the IDDT fidelity scale rating sheet that includes a summary of findings and recommendations that assist programs in improving fidelity to each of the 25 characteristics. The information obtained from fidelity reviews is then analyzed and reviewed by the SAMI CCOE.

According to Bond (2007), "modest implementation efforts lead to modest fidelity, which in turn leads to modest outcomes." If a treatment program receives a low fidelity rating, client outcomes are not attributed to the original model (McHugo, Drake, Teague, & Xie, 1999; SAMHSA, 2002). McGrew, Bond, Dietzen, and Salyers (1994) defined fidelity as "conformity with prescribed elements and the absence of non-prescribed elements" (p. 670). The IDDT Fidelity Scale Rating Sheet operationally defines the critical components of the model, outlines the parameters of each item, and decreases the possibility of a program drifting from the original intent of the model. According to Biegel et al. (2003), the use of a standardized rating scale (i.e., the IDDT Fidelity Scale Rating Sheet) allows the SAMI CCOE to systematically evaluate programs and also allows future research focusing on implementation of the model.

Existing Research on Evidence-Based Practice Implementation

Various researchers have focused on the implementation of evidence-based practice. Research has ranged from implementation at the national level (i.e., the original eight states that committed to implementing the various evidence-based practices), the state level (i.e., comparing agencies in the state of Ohio that implemented evidence-based

practice), to implementation at the agency level (e.g., case study of an individual agency) in the state of Ohio.

At the national level, McHugo et al. (2007) examined implementation of the five evidence-based practices across a 2-year period of time. Participants in the study were the 53 community-based mental health centers throughout 8 states that were part of the National Implementing Evidence-Based Practices Project. The study had two purposes: (a) "to discern whether certain evidence-based practices were implemented more faithfully than others" and (b) "to examine change over time in fidelity within each evidence-based practice in order to determine the critical time exposure for successful implementation" (McHugo et al., p. 1280). The outcome measure for their study was fidelity to the model. Fidelity measures were gathered prior to implementation and every six months until the termination of the study at 24 months. Findings of the study indicated that implementation of evidence-based practices is possible within community mental health settings. These findings are supported by data that reveal a 59% rate of high fidelity to evidence-based practices over a 2-year period of time. According to the authors, the largest gain in adherence to fidelity occurs within the first year of practice. After the first year, gains in fidelity scores leveled off, with the exception of one practice (i.e., family psychoeducation). Findings also indicated that some of the evidence-based practices (i.e., assertive community treatment and supported employment) may be easier to implement. Other evidence-based practices (e.g., IDDT) require knowledge of and changes to clinical interventions, which necessitates extensive supervision and training (McHugo et al.).

Isett et al. (2007) also examined implementation of five evidence-based practices at the national level. However, this study focused on the role of state mental health authorities as change agents. The state mental health authorities in this study were from the eight states that had agreed to adopt one or more evidence-based practices as part of the Evidence-Based Practices Project. In all, 30 participants were included in this study and consisted of state mental health authorities, families, consumers, representatives of local mental health authorities and other relevant state agencies (Isett et al.). According to the authors, the focus of the study was the role of the state in the implementation process, along with the role of state mental health authorities in three critical areas: (a) financing and regulations, (b) leadership, and (c) training and quality. Findings of the study indicated that if an evidence-based practice was doing well in a particular state, the state mental health authorities were effectively addressing the three critical areas (e.g., providing training to front-line clinicians, creating ways to finance practices). Findings also indicated that unique challenges of implementation were present within each of the evidence-based practices (e.g., different regulations, different stakeholder groups, and different obstacles related to implementation). In regard to IDDT, findings indicated that specific challenges were present during implementation. These included the integration of treatment (i.e., mental health and substance use), funding (e.g., different administrative and regulatory rules for funding streams) and coordination of treatment (e.g., substance abuse and mental health agencies). Findings also indicated that the lack of knowledgeable providers was problematic. The authors state that prior to implementing any evidence-based practice, states need to be aware of constraints of resources (e.g., money, time,

attention) required of each practice. The authors found that states that had chosen to implement two practices fell behind in implementation because of such constraints. Therefore, they caution states interested in simultaneously implementing evidence-based practices because of the specific challenges inherent in each practice and suggest that states implement one practice at a time.

At the state level, the Innovation Diffusion and Adoption Research Project (IDARP) has produced research on outcomes and implementation efforts in the state of Ohio (Panzano et al., 2002). IDARP has also examined viewpoints of employees in behavioral healthcare organizations on evidence-based practice, their experiences of implementation, and whether or not the source of initial information about an evidence-based practice (e.g., journal, colleagues) affect the decision to adopt an evidence-based practice.

The Ohio Department of Mental Health and the MacArthur Foundation funded the Innovation Diffusion and Adoption Research Project (IDARP) in order to facilitate research on evidence-based practices in the state of Ohio. Two broad questions were the main focus: "1) What factors and processes influence the adoption of EBPs by behavioral healthcare provider organizations, and 2) What factors and processes contribute to the longer-term assimilation and impacts of EBPs by adopting organizations"? (ODMH, 2007a, p 1). IDARP was a longitudinal study from 2001 to 2005 with data gathered at three intervals. IDARP research focused on four evidence-based practices: (a) Cluster-Based Planning; (b) Multi-Systemic Therapy; (c) the Ohio Medication Algorithms Project; and (d) Integrated Dual Disorder Treatment. Separate Coordinating Centers of

Excellence (CCOEs) were created in Ohio for each practice in order to disseminate the models, and IDARP "examines the decisions and actions of organizations that interacted with CCOEs regarding the potential adoption of one of four practices" (Panzano et al., 2007, p. 78). IDARP did not examine each evidence-based practice individually; instead, research integrated all four evidence-based practices. Participants included administrative staff (e.g., agency executive directors), front-line clinicians (e.g., case managers), CCOE staff, mental health board staff, and staff from community service systems.

IDARP researchers examined outcomes and implementation efforts that included (a) the adoption decision, (b) multi-level model of implementation success, (c) cross-phase effects on implementation outcomes, and (d) effects of implementation variables over time (Panzano et al., 2002). Data was collected through individual interviews and follow-up surveys. According to the authors, the decision to adopt an evidence-based practice is based on whether or not the benefits outweigh the risks of adoption, whether or not the organization can handle the risks associated with adoption, and whether or not the organization is innovative (Panzano et al., 2002). Additional findings suggested that because of the complexity of implementing an evidence-based practice, performance monitoring at all levels throughout implementation was important in increasing success of implementation. According to Panzano et al., if perceived advantages of adopting a practice were strong at the beginning of implementation and if staff were committed to implementation, the likelihood of sustaining an evidence-based practice is greater. One last finding indicated that support from top management is a key to successful implementation (Panzano et al.).

Panzano et al. (2007) examined the qualitative data gathered during the three intervals of the study and presented findings related to planning process, barriers and facilitators, and program evaluation. The planning process focused on activities that the agencies engaged in prior to implementation and was broken down into five categories, including: (a) formulation, (b) concept development, (c) detailing, (d) evaluation, and (e) implementation (Panzano et al.). According to the data, agencies that adopted or implemented the model spent more time during the planning process compared to agencies that (a) did not adopt the model, (b) were still considering adoption, or (c) those that terminated the program. Panzano et al. also examined the number of barriers and facilitators mentioned by implementers during the first and second round of interviews. These were broken down into five categories: (a) CCOE, (b) money, (c), other, (d) staff, and (e) system. Findings indicated that from the first to the second round of interviews, the number of references to barriers remained stable while the number of references made to facilitators decreased (Panzano et al.). Whereas the planning process occurred prior to implementation, program evaluation focused on activities that agencies were already engaged in or were planning on engaging in once the practice was implemented. Information about program evaluation was gathered from agencies that were implementing the four evidence-based practices during the second round of interviews and focused on both process and outcome evaluation, and evaluation of the impact of implementing the practice (Panzano et al.). Findings indicated that agencies were aware of the need to evaluate the programs that they had implemented. Agencies that were implementing the IDDT model and Multi-systemic Therapy made more references to

program evaluation than their counterparts. Panzano et al. attributed this finding to the salience of program evaluation within these projects.

IDARP also disseminates information on research findings through a Bulletin, which is posted on the Ohio Department of Mental Health website (http://www.mh.state.oh.us/oper/research/idarp/index.html). IDARP researchers explored the adoption process and whether the initial source of information about evidence-based, promising, or best practices (e.g., colleague, written information, seminars, ODMH, or CCOE) would impact the decision to adopt. Information for this study was obtained through interviews with 144 decision makers and a follow-up survey (ODMH, 2006). Findings indicated that of the various sources of information available, information obtained from a colleague is the most influential in the decision to adopt an innovation (ODMH, 2006). When comparing agencies that adopt innovations to agencies that decide not to adopt innovations, the findings indicated that the first source of information is a key discriminator when considering other factors that are expected to impact the decision to adopt (ODMH, 2006).

Massatti (2006) also explored the perceptions of early adopters (n = 72) and asked the participants to reflect on their experiences of implementation and what they would have done different. Five themes emerged from the data collection: (a) staff issues, (b) EBP issues, (c) system issues, (d) CCOE issues, and (e) financial issues (Massatti). In reflecting on experience, early adopters would have addressed staff issues throughout the implementation process. Staff issues included increasing staff supervision, development (e.g., training) activities geared toward the evidence-based practice, and dedicating full-

time staff to implementation instead of splitting staff time between the evidence-based practice and other job duties. Because of staff turnover, participants stressed the need for ongoing training on the practice (Massatti). EBP issues included increasing the length of time to roll out the practice. For example, within the IDDT model, various components would be implemented at the same time. Participants also stated that they wished they had addressed problems with adherence to the model early in the implementation process (Massatti). Within system issues, participants stated that they had not involved all the stakeholders (e.g., community members) when considering implementation and felt that the groundwork for community support was not established (Massatti). In relation to CCOE issues, participants stated that adoption and implementation would have been smoother if they had contacted the CCOE at the beginning. Finally, participants felt that more money should have been set aside for implementation in order to ensure a practice that could be sustained (Massatti). According to the participants, organizational leadership that is supportive can address these issues prior to and during implementation in order to ease the process of implementation (Massatti).

IDARP researchers interviewed 193 participants about facilitators and barriers related to adopting and implementing evidence-based practices (ODMH, 2007b). Three types of participants were identified: (a) project sponsors, (b) implementers, and (c) decision makers. After data was collected, it was sorted into six categories that included: (a) the CCOE, (b) EBP fit (the philosophical and logistical fit of the practice), (c) system, (d) funding, (e) staff attitudes, and (f) implementation know how (e.g., necessary expertise). The facilitators and barriers within each of the six categories were identified,

and the ratio of facilitators to barriers was presented (ODMH, 2007b). For example, implementers identified almost three CCOE facilitators for every one barrier (ODMH, 2007b). According to the findings, the CCOE, the fit of the evidence-based practice to the organization, and the system were identified more often as facilitators to implementing an evidence-based practice. Funding and implementation know-how were more often identified as barriers to implementation.

Whereas the IDARP produces research focusing on four different evidence-based practices throughout the state of Ohio, the SAMI CCOE has produced research focusing solely on implementation of the IDDT model throughout Ohio. SAMI CCOE staff has published articles that include the comparison of facilitators and challenges of implementation (Boyle & Kroon, 2006), the importance of staff selection in implementing the model (Wieder, Boyle, & Hrouda, 2007), and lessons learned during implementation in the state of Ohio (Boyle & Wieder, 2007).

In their article on IDDT implementation in the state of Ohio, Boyle and Wieder (2007) focused on the observed challenges of implementing the IDDT model and offered strategies that could assist agencies during the implementation process. According to the authors, supervision, staff selection, and training appeared to be important factors during the implementation process. Strategies to increase effectiveness of IDDT supervision included but were not limited to: (a) when selecting supervisors, there should be a match between the IDDT model and the prospective supervisor; (b) supervisors should have opportunities to engage in training, peer networking, and consultation; and (c) evaluate the Team Leader's role and responsibilities. Strategies for supervision and training

included but were not limited to: (a) ongoing in vivo clinical supervision and monitoring should be provided to maintain skills; (b) applied and didactic learning should be interspersed and integrated; and (c) instead of one-day training sessions, provide mentoring to staff. According to Boyle and Wieder (2007), CCOE consultants and trainers "assess each organization's stage of implementation and relevant, stage-appropriate strategies to ease the process of IDDT installation" (p. 108). CCOE staff meets weekly to discuss client (e.g., organizational) needs: similar to what the IDDT team is asked to do with clients.

Wieder et al. (2007) collected data from four agencies implementing the IDDT model over a 2-year period of time. Implementation success was measured by ratings on an early version of the IDDT fidelity scale. The authors used a qualitative methodology to gather data and from the existing data, they extracted data on Team Leader and team member selection (Wieder et al.). Higher fidelity to the model was associated with specific characteristics (i.e., personal traits and professional attitudes) of the practitioners (Wieder et al.). Findings indicated that good clinical skills, the quality of IDDT supervision, strong administrative support, and the enthusiasm of the Team Leader were critical components of new teams (Wieder et al.). Other important findings were the importance of the Team Leader's managerial skills and leadership capability, and the ability to foster team cohesiveness. The authors also compared the difference between team members who were recruited and those who were designated to the team and found that members who were recruited were more motivated, open to change, and enthusiastic than their counterparts (Wieder et al.). According to the authors, if team members were

willing to learn the model and were open and enthusiastic, the lack of knowledge about the model did not hinder implementation. Findings indicated that those in a position to hire new team members tended to select individuals who were client-focused, comfortable with treatment that was community-based, and tolerant of a treatment perspective that was long-term (Wieder et al.). Other findings indicated that the use of a screening device (e.g., informing staff about various issues, including but not limited to the demands of the work and the type of work involved in implementation) prior to implementation was effective. According to the authors, individuals who are more receptive to change and willing to both learn the model and work with a challenging population appeared to have better outcomes (Wieder et al.). Staff turnover was identified as a challenge and costly in relation to staff training. Expert supervision, along with experienced team members, appeared to lessen the burden of turnover on trainings.

Wieder and Kruszynski (2007) focused on staff selection and its importance in implementing the IDDT model. The authors present a case study of one agency in the state of Ohio that was implementing the IDDT model. Within the agency, leadership did not take into consideration the demands of implementation, which included the need to have staff dedicated solely to the model, and having staff on the team who believed in the model and were willing to learn new concepts. Leadership also did not define the role of the substance abuse specialist. This resulted in difficulty learning the model and not grasping concepts that were vital to implementation (e.g., stage-wise treatment and motivational interventions; Wieder & Kruszynski, 2007). At the beginning and throughout implementation, a consultant-trainer worked with staff. According to the

authors, the quantity and quality of training provided by the consultant-trainer had a positive impact on implementation (e.g., assist staff in mastery of core skills; Wieder & Kruszynski, 2007). Approximately 12 months into the implementation process, the IDDT program went through a restructuring process, and staff was recruited (versus assigned) to join the team. According to Wieder and Kruszynski, the new team members were enthusiastic, optimistic, and more positive about the model. Over a 12-month period of time, the program showed modest but continued growth. Findings indicated that mastery of core IDDT skills was more readily facilitated by staff that was open and ready to adopt core principles. Other findings included the importance of expert ongoing supervision, ongoing technical assistance, and realistic expectations of the Team Leader role that included administrative support and time (Wieder & Kruszynski).

The intent of the Evidence-Based Practices Project and the creation of centers (e.g., SAMI CCOE) was to assist mental health agencies in providing effective services to individuals with severe mental illness and potentially narrow the gap between research and practice. Agencies and clinicians would be held accountable for services provided, and the quality of services rendered would be improved. However, not all researchers approve of the use of evidence-based practice and have presented various arguments against the use of evidence-based practice.

Arguments Against the Use of Evidence-Based Practice

Various researchers have come forth to challenge the use of evidence-based practice (e.g., Anthony et al., 2003; Dixon, 2004; Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Persons & Silberschatz, 1998; Tanenbaum, 2003, 2005). Their arguments are both

thought provoking and disputable, ranging from the loss of individuality within evidence-based practice to defining evidence.

Fulfilling a Political Agenda

Tanenbaum (2003) stated that evidence-based practices are well suited for the political agenda of the current U.S. public mental health system. That is, evidence-based practice diverts attention from the failures of a fragmented mental health system and deinstitutionalization and places the blame on clinicians who have allegedly provided treatment that was not informed (i.e., not based on science).

The historical vision of treatment was based on the idea that individuals with mental illness were unable to make life choices and providers knew what was best (Anthony, 1993). For example, the concept of deinstitutionalization was based on incorrect assumptions that people with severe mental illness had family support and places to live in the community (Accordino, Porter, & Morse, 2001). These incorrect assumptions led to negative consequences for individuals with severe mental illnesses (e.g., homelessness) that have persisted since the inception of deinstitutionalization. Mechanic and Rochefort (1990) referred to deinstitutionalization as "one of the era's most stunning public policy failures" (p. 302).

The concept of deinstitutionalization was publicly introduced by President John F. Kennedy in 1963 through the Community Mental Health Centers Act (Mechanic & Rochefort, 1990). The goal of deinstitutionalization was to reduce the number of patients in psychiatric hospitals by 50% over a period of 10 to 20 years (Mechanic & Rochefort). In 1955, 559,000 individuals were in psychiatric hospitals. By 1985, the number of

individuals in psychiatric hospitals had decreased to 110,000. Unfortunately, the community was unable to meet the needs of individuals with severe mental illness (Anthony, 1993; Hatcher & Rasch, 1980; Mechanic & Rochefort, 1990). Monies that were expected to be allocated to mental health agencies did not materialize, and, over time, the system eroded (Mechanic & Rochefort, 1990; SAMHSA, 2005). As a result, numerous individuals with mental illness remain untreated, living on the streets and in prison or jail for offenses committed while symptoms were active (E.F. Torrey & Zdanowicz, 1998).

According to Tanenbaum (2003), the mental health system is deficient for various reasons (e.g., lack of funding, restrictive state regulations) and clinical treatment is only one aspect of a complex problem. She stated that the public perceives mental health practice as ineffective:

> Even if the public never gets specifics [regarding the numerous aspects of failure within the mental health system] . . . it should be clear to them that clinicians are in the wrong. Blame can be crucial to a public idea because the solution to the problem is implicit in who is to blame. (p. 294)

In other words, if the public perception is that uninformed practice by clinicians is to blame, then evidence-based practice is the solution to the problem because clinicians will need to adhere to specific guidelines. According to Tanenbaum (2003), this public idea diverts attention from the complexity of the problem and in the end, the perception of failure rests on the practitioner instead of on the shoulders of those who are truly accountable (e.g., mental health authorities). Although Tanenbaum's argument is solid,

the New Freedom Commission (2005) recognized the need to restructure the entire mental health system, pointing out the numerous barriers to effective treatment. Clinical practice was not the sole focus of attention; rather, it was identified as one of numerous areas that need to be redefined.

The Recovery Model

Another argument against evidence-based practice comes from individuals who support the Recovery Model (Anthony et al., 2003; Frese et al., 2001; Tanenbaum, 2003). Within the Recovery Model, the focus is on clients, and clients are given control of and responsibility for recovery from a mental illness. Clients can choose which type of treatment is most effective for their needs, along with choosing whether or not to engage in treatment. Anthony (1993) described recovery as:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (p. 13)

According to the National Consensus Statement on Mental Health Recovery (U.S. DHHS, 2006), there are 10 fundamental components of recovery. Over 110 stakeholders (e.g., mental health consumers, researchers, state and local public officials) participated in defining the concept of recovery (see Table 6). Recovery does not mean that the mental illness is cured; rather, the symptoms no longer consume or define the individual

Table 6

Definition of Recovery

1. Self-directed by clients, who choose their life goals along with the path to achieve such goals
2. Individualized and person centered, focusing on individuals' strengths, resilience, experiences, preferences, needs, and cultural background
3. Empowerment, where individuals can choose from a range of options and participate in all decisions, allowing individuals to gain control of their own destiny
4. Holistic, encompassing all aspects of the individual's life
5. Non-linear, based on growth, learning from experience, and occasional setbacks
6. Focused on strengths in order to leave behind damaged life roles and move individuals forward toward developing supportive and trusting relationships
7. Engagement with a network of peers in order to build mutual support and provide a sense of belonging, community, valued roles, and supportive relationships
8. Acceptance and appreciation of individuals by the community systems and society along with the elimination of stigma and discrimination
9. Responsibility of individuals for self care and the journey of recovery
10. Hope that is internalized by individuals and fostered by support networks

Source: U.S. Department of Health and Human Services, 2006

(Anthony, 1993). Individuals are able to move beyond the effects of the illness and not only find meaning, but also make life choices according to their own desires.

Frese et al. (2001) stated that evidence-based practices are not based on recovery and are better suited to individuals whose judgment is severely impaired. Such individuals are unable to make treatment decisions on their own and are in need of care from external sources. Individuals who are in the latter stage of recovery should be given the choice to decide which type of treatment to engage in rather than being given one choice of treatment modality (e.g., IDDT; Frese et al., 2001). It appears as if the recovery model and evidence-based practices are philosophically opposed; however, this is far from the truth.

Whereas the Recovery Model focuses on individuals with a mental illness and encourages personal choice in treatment options, evidence-based practice focuses on changing organizational and provider approaches to individuals diagnosed with a mental illness. The core component of the IDDT model is shared decision-making and clients determine what, if any, changes need to be made in order for them to effectively manage their lives. Decisions about client care are not made by providers without client input. According to Mueser, Noordsy, et al. (2003), individuals with co-occurring disorders "are capable of playing a vital role in the management of their disorders and in making progress toward achieving their goals" (p. 20). Providers focus on helping individuals build skills and supports in the community in order to be independent. Providers also focus on teaching clients about symptoms and the management of symptoms, with the

overarching goal of assisting individuals with a mental illness to successfully integrate into the community (Drake et al., 2005).

Evidence-based practice demands that both the organization and practitioners be accountable for and maintain effective treatment. On-going training and supervision of providers is built into the IDDT fidelity scale to ensure clinical competency, which is vital to the successful implementation of any treatment model (Chambless & Hollon, 1998). Clinical competency is clearly defined in Section C of the *ACA Code of Ethics* (American Counseling Association, 2005) as a counselor's ethical responsibility not only to provide services based on science, but also to practice within areas in which he or she is competent. Clinical competency is an ongoing process that requires continuous training, specifically in areas that are new to a clinician (Chambless & Hollon, 1998).

Evidence-based practices were not developed to limit client choice in treatment; rather, they were developed so that agencies and practitioners would be accountable for documenting adherence to treatment based on science and offer a range of treatment options from which clients can choose. Each evidence-based practice focuses on numerous facets of treatment that work together to assist clients in achieving recovery. The treatment facility adheres to factors within the model but does not insist that clients engage in services. For example, in the IDDT model, the organization must provide services to families and significant others. It must also raise awareness of self-help groups in the community and link clients to these groups if clients are interested. The basic premise is that an array of services is offered, and clients are given the choice of whether or not to engage in them.

The Definition of Successful Treatment

Another argument against evidence-based practice is that the definition of successful treatment (i.e., client outcomes) according to evidence-based practice is different from what the recovery model (Anthony et al., 2003) defines as successful treatment. According to Anthony (1993) and Anthony et al. (2003), evidence-based practices focus on objective outcomes such as lowered utilization of hospitals, decreased symptoms, and employment instead of focusing on personal goals that have been identified as meaningful to the individual such as self-esteem, adjustment to disability, self-determination, and empowerment.

Within the recovery model, outcomes focus on each individual instead of overall outcomes of a program. For example, within the IDDT model, lowered utilization of hospitals is equated with successful (organizational) implementation of the model. However, according to Anthony et al. (2003), a brief hospital stay may be in the individual's best interest (e.g., stabilization of symptoms away from a stressful environment). If an organization is focused on keeping clients out of the hospital in order to achieve better outcomes, individuals may be unintentionally harmed in the process. Drake (2005) countered this argument by stating that outcomes within evidence-based practice are aligned with the recovery model and according to the New Freedom Commission report (2005), evidence-based practices clearly incorporate the concept of recovery (i.e., client choices and preferences are paramount).

Defining Evidence

Another argument against the use of evidence-based practice is that only a few select practices that have withstood numerous randomized controlled trials will be adopted and other forms of treatment will be excluded if the research base is not considered sufficient (Anthony et al., 2003; Dixon, 2004; Tanenbaum, 2003). Although randomized controlled trials (RCTs) are considered to be the *gold standard of evidence* in research, numerous individuals challenge the use of RCTs as the sole research method to determine what constitutes evidence (Goldfried & Wolfe, 1998; Tanenbaum, 2005; Zlotnik & Galambos, 2004).

The success of RCTs for drug therapies, or clinical trials, was adopted as a standard means to evaluate psychotherapy research in the 1980s (Goldfried & Wolfe, 1998). Randomized controlled trials are equated with efficacy and although they are valuable in guiding clinician's work, using RCTs as the sole methodology in psychotherapy research is questioned (Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998; Tanenbaum, 2003; Zlotnik & Galambos, 2004). Randomized controlled trials focus on efficacy, or internal validity, not effectiveness, or external validity, resulting in a gap between research and practice because many times a study is not relevant to clinical practice (Chambless & Hollon, 1998; Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998; Tanenbaum, 2005).

According to Howard et al. (1996), researchers and practitioners ask different questions when looking at treatment. Whereas the researcher asks whether a specific treatment works under rigid, experimental conditions, the clinician asks what treatment

will work for a particular individual and whether the treatment will work in actual practice. Although the need for efficacy research is irrefutable in guiding practice, researchers also need to focus on effectiveness research in order to bridge the gap between research and practice (Chambless & Hollon, 1998; Goldfried & Wolfe, 1998; Tanenbaum, 2005).

Various aspects of RCTs are questioned in the literature (Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998; Zlotnik & Galambos, 2004). Persons and Silberschatz (1998) stated that although the use of random assignment minimizes bias and internal confounding, numerous individuals (e.g., individuals with multiple problems and diagnoses) are excluded from studies in order to obtain a homogeneous or representative sample of a diagnostic category. In practice, clinicians treat individuals with multiple diagnoses and problems, making it difficult to transfer RCTs to practice (Fensterheim & Raw, 1996; Persons & Silberschatz, 1998). For example, many RCTs focus on a diagnostic category and do not take into account that mental illness is idiopathic (e.g., symptom presentation is not consistent and affects the individual in different ways). According to Goldfried and Wolfe (1998), if two treatments are compared in RCTs, success is due, in part, to a match between treatment and the individual.

Truman and Raine (2001) and Zlotnik and Galambos (2004) argued that because evidence of efficacy is equated with RCTs, studies that focus on gathering quantitative data will be placed at the forefront and treatments that have not proven effective through RCTs will be excluded from the evidence base. For example, according to Tanenbaum

(2005), the District of Columbia only permits the use of Dialectical Behavior Therapy (DBT) with individuals diagnosed with borderline personality disorder even though psychoanalytically oriented psychotherapy has produced at least one RCT that supports its efficacy. Another example is self-help groups that have not been subject to rigorous research yet are highly effective (Dixon, 2004). According to Dixon, consumers and family members voice concern that because self-help groups have not produced evidence of efficacy through research, they will not be perceived as effective.

Another argument against the use of evidence-based practices is a lack of funding for practices that are not considered to be evidence-based. If funding streams focus only on those practices that have produced efficacy, then monies will not be available to create and test alternative practices that may be more effective. Furthermore, evidence-based practice is equated with cost effectiveness, resulting in governmental control over practice (Tanenbaum, 2005). According to Tanenbaum, in the state of Oregon, state agencies that do not provide evidence-based treatment suffer financial constraint. By 2009, 75% of Oregon's program budget will be delegated to agencies providing evidence-based practice. If agencies choose not to incorporate such practices, considerable consequences will ensue. In the end, agencies will be told how and what to practice.

Mueser and Drake (2005) acknowledged that new discoveries are often made through nonscientific evidence (e.g., personal experience, feelings or intuition), yet this type of evidence is highly subject to systematic distortion and bias. For example, if one individual's experience with an intervention is successful, this experience cannot

generalize to others based on the assumption that one successful intervention will work for all clients (Mueser & Drake, 2005). According to Mueser and Drake, "Many apparent discoveries [nonscientific evidence] are not reproducible" (p. 200), and efficacy must be established by scientific evidence (e.g., empirical, collected systematically, and strives to be objective) in order to eliminate bias and systematic distortion.

The Loss of Individuality Within Evidence-Based Practice

One final concern about the use of evidence-based practice is the need to rigidly adhere to a model and specific techniques rather than tailoring treatment according to individuals' problems and needs (Anthony et al., 2003; Dixon, 2004; Frese et al., 2001; Persons & Silberschatz, 1998; Tanenbaum, 2003). Omer and Dar (1992) wrote that "the best treatment is individualized to fit the patient" (p. 88). According to Anthony et al. (2003), evidence-based practice does not focus on the individual; instead, it focuses on how the service system provides services to a population within a specified framework.

The use of treatment manuals is also questioned. Although the use of treatment manuals has produced favorable results and allows for replication in research (e.g., Project MATCH, 1996), manuals can negatively impact both treatment and the therapeutic alliance by demanding adherence to a prescribed method (Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998). Treatment manuals focus on specific therapeutic techniques and strategies and exclude components of therapy that affect treatment such as therapist variables and the therapeutic alliance (L. F. Campbell, 1996; Fensterheim & Raw, 1996; Persons & Silberschatz, 1998). According to Campbell (1996), "the effectiveness of the therapist lies in the ability to adapt to the needs of the moment" (p.

191), and the use of treatment manuals inhibits clinician flexibility. Using an evidence-based practice, practitioners work within an established *cookbook* that does not allow for deviation from fidelity and results in the loss of flexibility within sessions and in planning treatment (Dixon, 2004; Persons & Silberschatz, 1998).

Humphries (2003) wrote that evidence-based practice focuses on behavior change and minimizes various aspects of a client's life (e.g., living environment, financial status) that can impact behavior and behavior change. According to Humphries, by using quantitative methods as the sole measure in research, the meanings, motives, influences, and doubts are lost, resulting in an incomplete picture of the individual. In other words, the idea that there are universal laws of cause and effect are unfounded because individuals make sense of their world in different ways, resulting in unpredictability in behavior. People cannot be categorized according to science and objective data, and therapy sessions cannot fit neatly into a specified mold (Goldfried & Wolfe, 1998; Humphries, 2003; Persons & Silberschatz, 1998). If therapists attempt to customize sessions according to evidence-based practice, spontaneity is eliminated and therapeutic effects are compromised. One alternative is to use the results of RCTs as a guide to practice and then individualize knowledge to therapy sessions, modifying treatment according to individuals' needs (Persons & Silberschatz, 1998). Another alternative is to integrate various research methodologies (e.g., participatory, qualitative) into the research base to complement the numerical data and allow for an understanding of the subjective experience of clients (Anthony et al., 2003; Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998; Tanenbaum, 2003, Zlotnik & Galambos, 2004). As a result, therapists

would not need to rigidly adhere to outcomes that may not account for individual differences and may be more willing to incorporate research findings into practice.

Although each of these arguments appears solid, they are disputable. Miller, Zweben, and Johnson (2005) provided a compelling argument in favor of the use of evidence-based practice. They parallel the use of evidence-based practice in behavioral health care to its use in general healthcare and state that all clinicians need to provide the most effective and current treatment available. However, according to Miller et al., the behavioral health care field has not been held to the same standards as the medical field, and clinicians in the behavioral health care field continue to provide services that have been proven ineffective in practice. Miller et al. stated that dissemination research acknowledges that an evidence-based practice does not work within every context but "USING an EBP is a sensible place to start" (p. 268).

Overall, the current mental health system in the United States is in disarray, and there is a lack of effective services being provided to individuals with mental illness. Furthermore, even though effective treatment has been identified, it is not always used in practice. This results in lower quality of care for individuals who could benefit and maintain a higher quality of life from such services.

Transferring Research to Practice

Although evidence-based practices have been identified, they are not always adopted. Mueser and Drake (2005) stated that the typical length of time from development of an evidence-based practice to establishment is approximately 2 to 10 years. In addition, it takes approximately 17 years from the time that a new finding is

published to the time that the practice is actually used in the field (Institute of Medicine, 1998).

Diffusion of an Innovation

Rogers (1995) identified the process of transferring research to practice as diffusion of an innovation. Diffusion is equated with the communication of an idea that is either spontaneous or planned and ultimately results in social change. According to Rogers, four main elements are distinguishable within every diffusion research study: (a) the innovation, (b) time, (c) communication channels, and (d) the social system.

The actual innovation is the first element. An innovation may be a new idea or it may have been in existence for a period of time; however, once it is perceived as new by an individual or system, it is considered to be an innovation (Rogers, 1995). Time is the second element in a diffusion research study and includes the innovation-decision process, early and late adopters, and rate of adoption. For example, although effective treatment exists, it is not always implemented or available. The most striking example of this were the findings from the Schizophrenia Patient Outcomes Research Team (PORT), where less than half of the participants in the study received recommended treatment (Lehman & Steinwachs, 1998; W.C. Torrey et al., 2001).

In order to implement an innovation, the third element of communication channels needs to be developed. These consist of either mass media (e.g., radio, newspaper, television) or interpersonal channels (i.e., a face-to-face exchange). Whereas mass media channels rapidly spread information about the innovation, Rogers (1995) stated that interpersonal channels are more effective in the adoption of an innovation.

Interpersonal channels include the evaluation of a specific innovation from peers. If the innovation is perceived as beneficial by the peer, the likelihood of adoption increases. For example, the SAMI CCOE established interpersonal channels by building relationships between and among all stakeholders and continuously reinforces these channels (e.g., yearly conference, training workshops). Furthermore, by including an individual into the external fidelity review team who has been a part of a treatment program that has closely adhered to the IDDT model, newer programs can benefit from the experiences of successful programs.

The fourth factor in the process of diffusion is the social system (e.g., organizations, individuals, subsystems), which is vital to the adoption or rejection of an innovation. For example, although needle exchange programs have resulted in positive findings, the current social system (i.e., federal agencies) within the United States impedes the progress of this innovation (Drucker, 2005). Panzano and Roth (2006) found that the decision to adopt an innovative mental health practice is based on risk versus benefits. According to the authors, "early adopters act because they see the risks associated with adopting [an innovation] as lower than their nonadopter counterparts, partly because the risks are seen as more manageable" (p. 1159).

Stages of Change Applied to Systems and Diffusion of Innovation

A basic understanding of stages of change is helpful in considering the diffusion of an innovation. Whether the stages of change apply to an individual, system, or decision-making body (e.g., organization), the concepts inherent in each of the stages are

similar and useful in conceptualizing the process of adopting an innovation (see Table 7). Each of the five stages of change is discussed in detail in this section.

Table 7

The Stages of Change as Applied to Individuals, Systems, or the Decision-Making Body

	Prochaska, Norcross, and DiClemente (1992) Individual	Solomon and Fioritti (2002) Systems	Rogers (1995) Decision-Making Body
Stage 1	Precontemplation	Precontemplation	Knowledge
Stage 2	Contemplation	Contemplation	Persuasion
Stage 3	Preparation	Determination	Decision
Stage 4	Action	Action	Implementation
Stage 5	Maintenance	Maintenance	Confirmation

Within the first stage of change, the decision-making body or system is either exposed to an innovation that fulfills a need or a need is identified, leading to an innovation (e.g., integrated treatment). Although various innovations may be created to fulfill an identified need, not all innovations are adopted, or it can take years before an innovation is adopted. Raising consciousness (Prochaska, Prochaska, & Levesque, 2001) as well as adequate knowledge and relevance of an innovation are vital for adoption (Rogers, 1995; Solomon & Fioritti, 2002). The SAMI CCOE has increased awareness of the need for integrated treatment through the use of mass media channels (e.g., newsletters, Internet) and interpersonal channels (e.g., connecting existing IDDT programs with agencies in the early stages of implementation).

Within the second stage of change, the need for innovation has been identified, and an opinion on the innovation is developed (Rogers, 1995; Solomon & Fioritti, 2002). Uncertainty about the innovation is prevalent, and the system or decision-making body pursues information on the innovation's disadvantages and advantages. The decision to adopt an innovation is enhanced when the system or decision-making body has contact with another entity that is satisfied with the innovation (Rogers, 1995). According to Panzano and Roth (2006), an organization is more likely to adopt an evidence-based practice if it is well informed about the practice and engaged in information gathering from peers. The CCOE reinforces the relevance of the model to daily practice by educating stakeholders (e.g., clinicians, program leaders) about the IDDT model and assisting with implementation. According to Rogers (1995), rapid adoption is more likely to occur if the innovation is perceived as compatible (e.g., consistent with existing values or needs), observable (e.g., results are visible), easy to understand, better than its predecessor, and experimental (i.e., tried on a limited basis). When compared to individual change, organizational change is more complicated (Ohio SAMI CCOE, 2006). Whereas individual change affects one individual, change within an organization affects various individuals who may be in varying stages of change. Organizational change also impacts structures, policies, and practices.

Once a system chooses to adopt an innovation, it moves into the third stage of change where additional information on the innovation is pursued, and the commitment to change is strengthened (Prochaska et al., 2001; Rogers, 1995; Solomon & Fioritti, 2002). Goals are identified, along with strategies to implement them, and various

activities are put in place (e.g., training sessions, workshops) to confirm the commitment to change (Solomon & Fioritti, 2002). According to Kruszynski and Boyle (2006), during this stage, *change champions* (i.e., team members) are identified, and a steering committee comprised of key individuals (e.g., direct service representative, agency clinical and administrative leadership) is formed to help guide the agency's implementation process.

Many times, clinicians are neither ready nor willing to implement an evidence-based practice (Corrigan et al., 2001; McGovern, Fox, Xie, & Drake, 2004). For example, many clinicians do not have the skills and knowledge necessary to implement an evidence-based practice (Corrigan et al., 2001) and are less likely to adopt practices that are difficult to implement (McGovern et al., 2004). In addition, implementation of many evidence-based practices requires teamwork; however, various factors (e.g., lack of collaboration, burn-out, and poor leadership) can negatively impact implementation efforts (Corrigan et al., 2001). In order for the decision-making body or system to gauge the impact of potential barriers to implementation, an understanding of clinician attitudes, characteristics, and readiness to adopt a new practice prior to implementation is important (McGovern et al., 2004). By placing clinicians into stages of change and focusing on motivational interviewing interventions, a clear plan can be developed to implement an evidence-based practice (ATTC, 2000; McGovern et al., 2004; Solomon & Fioritti, 2002).

During the fourth stage of change, the planning established in the previous stage is put into use (Rogers, 1995; Solomon & Fioritti, 2002). It is during this stage that the

SAMI CCOE completes a baseline fidelity review in order to create the foundation upon which the agency will build its program (Kruszynski & Boyle, 2006). This stage is vital to the existence of an innovation as the organization prepares for change by training staff, providing supervision, and implementing new policies and procedures to provide structure for the program (Fixsen et al., 2005). During this stage, the environment and work habits need to be restructured in order to substitute old behaviors and cognitions with new behaviors and cognitions (Prochaska et al., 2001). This stage is fraught with numerous challenges.

One challenge during the fourth stage of change is the relevance of research to actual practice (Biegel et al., 2003). According to McGovern et al. (2004), an evidence-based practice may not fit with what clinicians are already doing in their daily work or may be too costly to implement. Biegel et al. (2003) stated that slight deviations (or re-invention) from the original (IDDT) model would need to take place at agencies throughout the state of Ohio (e.g., in rural locations, clinicians had substantial caseloads that exceeded recommendations, lack of appropriate housing for individuals with co-occurring disorders). Re-invention is defined as changes or modifications of an original innovation that are expected, especially within an organization (Rogers, 1995). According to Rogers, re-invention occurs due to complexity of an innovation, lack of knowledge about the innovation, or lack of monitoring. McHugo et al. (1999) questioned this practice, stating that modifications of an original model compromise fidelity and may jeopardize the success of the program. In their study, McHugo et al. found that programs with high fidelity achieved better outcomes and programs with low fidelity produced

poorer outcomes. Panzano et al. (2002) reported similar findings and stated that "the extent to which the practice is modified from its original tested form has a negative impact on success" (p. 87). Overall, core components of a model must be retained in order to achieve fidelity (Fixsen et al., 2005). As part of its research agenda, the SAMI CCOE is examining modifications of the IDDT model with other populations (e.g., inpatient services, adolescents; Ronis, 2004). Through the use of a fidelity scale that incorporates the core components of the IDDT model, re-invention can be monitored, and the SAMI CCOE can make comparisons among different programs and classify a program as having low or high fidelity to the model. Continuous education about the model, training, consultation, and fidelity visits minimize re-invention that could potentially affect fidelity.

Another challenge to successful implementation during the fourth stage is lack of collaboration within a multidisciplinary team. Norman and Peck (1999) attributed the lack of collaboration among team members to roles and responsibilities of staff that are not clearly defined. This results in conflict about team management, leadership, and lack of communication that affects the team (Norman & Peck). In addition, it is possible that individuals from varying professions may fear the loss of autonomy if they were to work within a team environment (Norman & Peck). For example, individuals from different disciplines have different values and cultures and do not view treatment from the same perspective (e.g., biological versus psychosocial). Even within one discipline (e.g., psychiatry), individuals are found to have differing philosophies (e.g., electroconvulsive

therapy vs. antidepressant medication; Geddes, Reynolds, Streiner, & Szatmari, 1997). This presents a challenge when implementing the IDDT model.

In order to maintain fidelity, varying disciplines need to work together and focus on clients' goals (e.g., continuing to use substances), which may require a shift in thinking. For example, nurses may have difficulty allowing clients to make choices that are contraindicated (e.g., refusing medication), knowing that clients may not attain a desirable quality of life (Pill, Rees, Stott, & Rollnick, 1999). The core value of the IDDT model, shared decision making, is based on the premise that clients have the ability to pursue and attain their own goals, function within society, and achieve recovery from both disorders (Corrigan et al., 2001; Drake, Morse, et al., 2004; New Freedom Commission, 2003). Uncertainty about the outcome of implementation is prevalent during the fourth stage, and the system actively pursues information on obtaining the innovation along with exploring operational problems and ways to solve them. According to Rogers (1995), implementation of the innovation eventually becomes an integral part of operations, signifying the end of the implementation stage.

During the fifth stage of change, the decision-making body or system recognizes the benefits or drawbacks of the innovation (Rogers, 1995). Fixsen et al. (2005) stated that a lack of attitudinal and structural changes within the organization, along with the lack of consistent use of practices taught, results in the failure to sustain a program. In order to sustain an evidence-based practice, implementation must be continuously monitored, clear outcomes must be established, and the philosophy of an evidence-based

practice must be incorporated into daily practice (Drake, Torrey, & McHugo, 2003; Mueser, Noordsy, et al., 2003; Shern & Evans, 2005; W.C. Torrey et al., 2002).

Providing consistent feedback to practitioners about the process of implementation and the outcomes derived from this process is another way to ensure the livelihood of an evidence-based practice (Fixsen et al., 2005). Overall, feedback is vital to learning (W. R. Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Furthermore, continuous supervision and coaching reinforces trainings and maintains awareness of the model and its components. By incorporating these elements into the IDDT fidelity scale (e.g., continuous training, outcome and process monitoring), the sustainability of the program is reinforced. The SAMI CCOE continuously monitors programs throughout the state and provides yearly fidelity reviews, giving feedback to organizations on implementation, along with providing strategies to increase fidelity to the model. Whether applied to individuals, systems, or decision-making bodies, the stages of change are not linear. The individual, system, or decision-making body can fluctuate and move into earlier stages of change if changes are not continually reinforced (e.g., continuous training and supervision).

Through continuous monitoring of individual, system, or decision-making body stages and working within the respective stages, the likelihood of success increases (Prochaska et al., 2001). For example, a leader may understand that the benefits of change clearly outweigh the current status of the organization. However, if the leader proceeds to make changes and employees are not ready to make such changes, staff resistance will more than likely cause the initiative to fail (Prochaska et al.). Therefore, it

is important to continuously stage all aspects of the organization (e.g., staff, systems) that will be impacted by the change and match interventions and interactions (e.g., raising consciousness) to stages in order to enhance movement through the stages (Prochaska et al.).

Within the organization, the IDDT Team Leader monitors the organizational and individual stages of change and works with the SAMI CCOE to increase the program's fidelity to the model. The IDDT Team Leader needs to be well versed in the model and understand each of the components (e.g., stages of treatment, cognitive-behavioral therapy, motivational interviewing) in order to change structures and processes to increase fidelity. Not only the SAMI CCOE but also the IDDT Team Leader are the bridges that potentially narrow the gap between research and practice. The SAMI CCOE supports the organization in implementation, but the IDDT Team Leader is responsible for implementation within the organization. Whether or not implementation is successful may be dependent on the IDDT Team Leader's character.

The Essence of Leadership

Leadership is a vital component in shaping the attitudes of staff and organizations, and the adoption of innovations (Aarons, 2006). Positive leadership ratings have been associated with positive attitudes about implementing evidence-based practice (Aarons). In defining leadership, Sankar (2003) stated that the leader's character is the critical measure of excellence in leadership. Sarros, Cooper, and Hartican (2006) stated that "character and good leadership are inextricably united" (p. 693). Due to its subjective nature, the study of character was abandoned by the scientific and professional

community in the 1920s (Sarros et al.) and has only recently been reconsidered (Sarros et al.; Sperry, 1997). Whereas reputation is how others perceive the individual, character is the essence of the individual and defines him or her (Klann, 2003). Although character is subjective, it is evident in behavior. For example, Klann (2003) stated that "leadership by example is the ability to influence others through actions and attitudes" (p. 5). Zauderer (2005) defined eight behaviors or dimensions of character referred to as character framework. These behaviors are presented in Table 8.

Table 8

Behavioral Aspects of Character

1. Leading a responsible life of deputyship
2. Displaying integrity
3. Moderating personality deficiencies
4. Displaying humility
5. Displaying fierce resolve
6. Aiming at the mean
7. Caring
8. Fostering civility

Source: Zauderer, 2005

The first behavioral aspect of character, deputyship, is defined as dedication and service to others (Zauderer, 2005). The focus is not on self-interest; instead, the focus is on working for others and caring about them in the same manner as a parent cares for a

child. Integrity is the second behavioral aspect of character that is guided by ethics and morals (Zauderer). Integrity is part of the individual and is consistent in daily interaction and behavior both in and out of the workplace (Thomas, 2005). After an extensive review of the literature, Zauderer (1992) identified 12 moral themes and principles that promote integrity and are evident in specific behaviors (see Table 9). A leader who displays integrity is able to gain trust within an organization and trust, according to Thomas (2005), is the single most important factor in healthy relationships between employers and employees.

According to Zauderer (2005), moderating personality deficiencies such as being mean, petty, or dubious is the third behavioral aspect of character. A leader with character is able to constrain destructive impulses associated with negative personality traits (e.g., excessive narcissism, excessively controlling disposition) and maintain awareness of negative personality traits in order to moderate behavior and enhance effectiveness (Zauderer, 2005).

Displaying humility is the fourth behavioral aspect of character (Zauderer, 2005). Humble leaders do not inflate themselves; instead, they are able to keep their own importance in perspective and focus on service to others (Zauderer). Such a leader listens to others with an open mind and actively engages others in inquiry. The fifth behavioral aspect of character, displaying fierce resolve, can be viewed as the opposite of humility. A leader with fierce resolve must have the courage to make difficult and controversial decisions (e.g., fire unproductive staff, disagree with others; Zauderer). However, the combination of humility and fierce resolve can result in extraordinary success because

Table 9

Behavioral Aspects of Integrity

1. Possess humility
2. Maintain concern for the greater good
3. Be truthful
4. Fulfill commitments
5. Strive for fairness
6. Take responsibility
7. Have respect for the individual
8. Celebrate the good fortune of others
9. Develop others
10. Reproach unjust acts
11. Be forgiving
12. Extend self for others

Source: Zauderer, 1992

the leader is focused on building something larger than self and can control feelings and behaviors in order to contribute to the greater good (Zauderer).

The sixth behavioral aspect of character is aiming at the mean. Zauderer (2005) describes this behavioral aspect as the ability to "constrain destructive impulses to under- or over-react in challenging circumstances" (p. 45). Therefore, the ability to regulate feelings, maintain self awareness, and sustain a balance between deficiency and excess is important in professional success (Zauderer, 2005). Klann (2003) stated that through

behaviors (e.g., responses to ethical dilemmas), the leader's moral strength becomes evident. Whether or not the leader is willing to compromise morals to achieve a goal (e.g., produce results at any costs) is an indicator of character (Klann).

Caring about the organization, citizens, customers, and individuals is the seventh behavioral aspect of character. A caring leader takes the time to gather facts prior to making decisions, will take the time to ascertain interests and expectations, and will continuously question personal motives prior to making decisions. According to Zauderer (2005), the caring leader is able to be both supportive and critical and cares deeply about the development of others and building strong organizations.

The eighth behavioral aspect of character is fostering an environment of civility at the workplace. An environment of incivility creates suffering and results in lost productivity, loss of commitment to the organization, and overall discontent (Zauderer, 2002). A leader who respects individual rights and fosters the dignity and self esteem of others creates an environment in which individuals feel welcome and included and can work together with mutual respect (Zauderer). This type of environment is conducive to enhanced organizational and individual productivity.

According to Sperry (1997), character is learned through various life experiences (e.g., culture, religion, traumatic experiences) and can change throughout one's lifetime. Sarros et al. (2006) wrote that character is seen as both a state (e.g., can be developed and learned throughout one's life) and a trait (e.g., enduring and stable). A leader can negatively or positively impact an organization depending on his or her character (Sperry,

1997). According to Sankar (2003), a leader is the key to shaping the organizational values and fostering a shared vision.

A leader sets the standards for the organization and plays a critical role in propagating an ethical culture within the organization (Sankar, 2003). According to Sankar, by fostering an ethically sound environment, a leader can create an environment that defines the organization's guiding values, supports ethically sound behavior, and instills a sense of shared accountability. Sankar attributed the current ethical-moral crisis in many occupations to the lack of moral leadership and character flaws of leaders within these organizations. Therefore, a leader's character must be assessed when evaluating leadership excellence (Sankar).

A leader needs to be able to develop a vision by examining the present and creating a direction for the future (Boyce, 2006). In other words, a leader needs to think outside of the current organizational structure and be willing to do something that has not been done before (Boyce). A leader is not content with the status quo and strives to better the organization by taking risks, openly discussing ethics, promoting diversity, being visible, and creating an environment rich with feedback (Klann, 2003). A leader focuses on getting something done and empowers and engages others in order to move the organization forward (Boyce, 2006).

The IDDT Team Leader

In order to implement the IDDT model, it is necessary to gain the support of numerous individuals within the organization, including the IDDT team members, because these individuals are the ones who implement the model. IDDT team members

(i.e., clinicians) consist of case managers, counselors, psychiatrists, and nurses. The IDDT Team Leader is a key component in the implementation process and can be likened to what Kouzes and Posner (2002) regard as an early adopter. This Leader is also a change agent and therefore, his or her leadership style (i.e., character) may impact the success or failure to implement the model. In the words of Kouzes and Posner, "Leaders are innovators; innovators are leaders" (p. 195).

As an innovator, the IDDT Team Leader must implement an innovation that is new to an organization. Therefore, the IDDT Team Leader's character is an important component during implementation. It is necessary for the IDDT Team Leader to establish credibility and foster trust among team members. Evidence of personal commitment, consistency, and follow-through on the part of the Leader are paramount in the implementation process. If the IDDT Team Leader believes in the model and leads by example, team members are more likely to follow.

The IDDT model is unconventional because it addresses more than one or two specific client needs (e.g., anger management, social skills; SAMI CCOE, 2006). In order to implement the IDDT model and adhere to fidelity, the service system, individual clinical practices, and organization need to be reinvented (SAMI CCOE, 2006). Therefore, the IDDT model is a change in current practice, and the Team Leader must challenge the status quo while eliciting action from team members. Challenging the status quo can be a formidable task. For example, W.C. Torrey et al. (2001) found that clinicians do not easily accept change and want convincing evidence of the need to change. According to clinicians, some of the challenges of implementing an evidence-

based practice include the need for substantial training necessary to gain competence in the model, long-term treatment that is difficult to implement due to recidivism, inadequate training and supervision, and the relevance of research to practice (Nelson, Steele, & Mize, 2006).

Clinicians are more likely to adopt a practice that can be carried out quickly and easily (Nelson et al., 2006), which may make implementation of the IDDT model more difficult due to its multi-faceted nature (e.g., stages of treatment, knowledge of motivational interviewing, and cognitive-behavioral therapy). On the other hand, clinicians stated that they would adopt a practice if they felt the practice would assist them in clinical areas where they lacked competence *or* if the practice was in demand (W.C. Torrey et al., 2001). In addition, clinicians are more willing to adopt a practice if the practice is reinforced over time (Nelson et al., 2006; W.C. Torrey et al., 2001). Continuous training and regular contact through weekly team meetings and supervision are perfect opportunities to foster cohesion and collaboration among the IDDT team members. Furthermore, these contacts reinforce practice of and competence in the model (W.C. Torrey et al., 2001), and develop a sense of mastery in each team member.

To successfully implement the model, the IDDT Team Leader needs to create an environment in which the team members can collaborate and trust each other in order to work toward the same goal. Norman and Peck (1999) stated that in order for the team to be effective, all aspects of power need to be addressed (e.g., roles and responsibilities of each member of the team, accountability within the team). The Leader needs to open communication channels between team members in order to separate sources of power

that are justified (e.g., level of expertise) and those that are not justified (e.g., according to personality or race) and establish clear roles on the team (Norman & Peck, 1999).

Leaders realize that they cannot achieve a goal on their own and foster mutual reliance within the team by using inclusive language such as *we* when discussing mutual goals (Kouzes & Posner, 2002). According to Glaser (2006), effective leaders engage and involve employees in decision making while establishing an open environment where employees can freely talk. As a role model, the Team Leader needs to trust that the team members are capable of decision-making (Kouzes & Posner, 2002) and allow the members to take ownership of, and be accountable for, implementation. According to Pfeffer (1999), although staff in healthcare organizations is skilled, their wisdom is often neglected. If team members believe that their role on the team is important, a sense of empowerment and pride in the program develops, and team members may be more willing to put time and effort into implementation. Listening to and seeking feedback from team members also builds coherence and a sense of ownership from members by knowing that their input is valued.

It is important to inspire passion in the IDDT team members and foster intrinsic motivation to implement the model (Kouzes & Posner, 2002). Leaders who have a clearly defined vision, along with a belief that the vision is attainable, inspire others to share in that vision (Glaser, 2006). According to Kouzes and Posner, "leaders live their lives backward. They see pictures in their mind's eye of what the results will look like even before they've started their project" (p. 15). The leader needs to maintain focus on this

vision, share it with others, and live it every day (Thomas, 2005). The leader who has a vision is able to be persistent despite setbacks or problems (Thomas).

The end result (i.e., outcomes defined in the IDDT model) is the vision that pulls the team forward. Results (i.e., outcomes) may not be visible for a substantial period of time (e.g., two years), but by working within the stages of change, progress is visible and can sustain the vision. Because of the challenges present with clients with co-occurring disorders, teamwork is necessary in order to avoid burn out (SAMI CCOE, 2001). Therefore, it is important for the IDDT Team Leader to develop and continuously encourage belief in the model. The ability to visualize and maintain the long-term goal sustains the IDDT team.

According to Jerrell and Ridgely (1999), robustness of implementation determines the effectiveness of dual diagnosis programs. The EBP Project was robustly implemented, and the SAMI CCOE and IDDT Team Leader create a strong bridge to narrow the gap between research and practice. However, despite efforts to ease implementation, numerous challenges within the current mental health system (e.g., financial inflexibility) and outside the purview of the EBP Project (e.g., stigma) impede implementation.

Challenges That Affect Implementation

Although the EBP Project was well thought out, external sources (e.g., the fragmented mental health system in the United States, stigma, and disparity in financial requirements and treatment limitations), along with separate systems of care and funding streams (i.e., substance abuse and mental health), present challenges that affect

implementation (Azrin & Goldman, 2005; New Freedom Commission, 2005; SAMHSA, 2003). Within community mental health agencies, staff turnover has been identified as problematic and is a challenge that requires ongoing training of staff in order to sustain implementation efforts (Boyle & Kroon, 2006). Yet another challenge for IDDT team members working in community mental health agencies is productivity requirements (i.e., the expected number of billable hours that the team member is meeting with clients) which make it difficult for the Team Leader to allot the necessary time to team meetings, supervision, and training (Boyle & Kroon).

Some of the challenges are currently being addressed (e.g., equal insurance payments for mental and physical health, early detection, building the scientific base, and consumer-driven treatment and rights; New Freedom Commission, 2003). However, others go beyond the breadth and depth of an evidence-based practice. For example, according to the National Survey on Drug Use and Health (U. S. DHHS, 2006a), approximately 49.2% of individuals with a co-occurring disorder did not receive treatment for either disorder whereas only 8.4% received treatment for both mental health and substance use. The prominent reason that clients did not pursue treatment was insurance or cost of care.

Another barrier to seeking treatment is stigma of both mental illness and substance use (ATTC, 2005b; Goldman et al., 2001; New Freedom Commission, 2003, SAMHSA, 2005). The effects of stigma on the individual can be as devastating as the symptoms of the illness (Corrigan & Penn, 1999). Individuals with mental illness are often perceived as violent and frightening (Accordino et al., 2001; E. F. Torrey, 1996).

According to Edwin Torrey (1996), only 5% of homicides nationwide are committed by severely mentally ill individuals who are not involved in treatment. Findings from a recent study by Swanson et al. (2006) indicated that violent behavior is uncommon among individuals diagnosed with schizophrenia. The public perception that violence and mental illness are related goes back to ancient Greece and the writings of Plato, who referred to how individuals who were mentally ill (i.e., *mad*) affected the safety of the citizens of Athens (Monahan, 1992).

Transforming public perceptions that have been ingrained in society is a noble cause and will take more than evidence of effective treatment to do so. Within the United States, individuals with mental illness have, for centuries, been placed in asylums and pushed into back wards of hospitals for society to ignore. Television and the media reinforce the perception that mental illness is frightening and self-determined (Monahan, 1992; National Alliance of the Mentally Ill [NAMI], 2005). During a publicity tour for an upcoming movie, the actor Tom Cruise openly stated that, "There is no such thing as a chemical imbalance" (NAMI, 2005). In addition, various movies (e.g., *Fatal Attraction*, *Psycho*) portray individuals with mental illness as psychopathic and violent, creating a stereotype that is difficult to change.

Other identified barriers to seeking treatment include the lack of knowledgeable providers (ATTC, 2005b; Azrin & Goldman, 2005), funding and financial inflexibility (e.g., Medicaid and Medicare; Drake, Essock, et al., 2001), cultural insensitivity, a lack of research on implementation (Azrin & Goldman, 2005; Corrigan et al., 2001; Fixsen et al., 2005; Goldman et al., 2001; Humphries, 2003), and fragmentation of delivery and

services (New Freedom Commission, 2005). According to the New Freedom Commission report, the current mental health system is in disarray and impedes recovery. The recommendation is to fundamentally transform how the system delivers care. Whether or not an evidence-based practice can be successfully implemented despite these barriers remains questionable and is an impetus for the current study. Because the IDDT Team Leader is in charge of implementing the IDDT model in an organization, he or she would be most able to provide answers about implementation within an organization in order to generate a substantive theory of implementation.

The Need for the Current Study

The efficacy of evidence-based practice has been established in the literature, yet little is known about how to implement evidence-based practice (Corrigan et al., 2001; Fixsen et al., 2005; Goldman et al., 2001; Humphries, 2003). That is, although efficacious treatment practices have been identified in research studies (namely randomized controlled trials), practitioners may not be equipped to implement such practices. There are numerous other challenges to implementation (e.g., diffusion of an innovation, separate systems of care, stigma). Despite these challenges, agencies throughout the state of Ohio have been working toward implementation. Therefore, an understanding of how IDDT Team Leaders prepared for and actually implemented the model despite challenges would increase the knowledge base concerning implementation of an evidence-based practice.

Whether or not an evidence-based practice can be implemented and sustained is an important consideration for researchers as well as agencies considering the use of an

evidence-based practice. In the current study, the subjective experiences of IDDT Team Leaders charged with the implementation of the IDDT model were brought forth, allowing for their voices to be heard. Areas that were explored in interviews with 6 IDDT Team Leaders included the transfer of knowledge to practice and whether or not a Team Leader eases the transfer, preparation, and strategies to implement. Challenges and facilitators encountered during implementation were also explored. Through the use of grounded theory, a preliminary theory of practitioner experiences of implementation of the IDDT model was generated to increase understanding of implementation.

Research Question

The primary research question that guided the current study was: How do 6 IDDT Team Leaders in Ohio describe their experiences of implementing the IDDT model?

Summary

A review of the literature was presented in Chapter 1. The need for the provision of effective services for individuals with co-occurring disorders is unquestionable and the argument for such services was clearly defined. Literature that examined the treatment of co-occurring disorders, including treatment models, the EBP Project, the SAMI CCOE, and existing research on EBP implementation was reviewed. Additional literature that was reviewed in Chapter 1 examined the transfer of research to practice, leadership, viewpoints of individuals who challenge the use of evidence-based practice, and challenges of implementation from sources outside the purview of the EBP Project.

In order to address the gap in the literature on implementation of an evidence-based practice, the current study focused on the exploration of the experiences of 6 IDDT

Team Leaders charged with implementation of the IDDT model in the state of Ohio. Through the use of grounded theory, the current study informed the field about the experience of implementing an evidence-based practice and generated a substantive theory on implementation to possibly guide future research studies.

The purpose of Chapter 1 was to review the literature and present the rationale for examining the experiences of IDDT Team Leaders who were charged with implementation of the IDDT model. Chapter 2 describes the methodology, participants, and procedure used in the study. It also describes how data were analyzed to create a substantive theory on implementation.

CHAPTER II

METHODOLOGY

Chapter 2 is organized into six sections. The first section addresses the lack of research on implementation and the purpose of the current study. The rationale for the chosen research design is described in the second section, and in the third section, the participants for the current study are described. Section four focuses on the procedures used in the current study and section five focuses on the assumptions of the researcher. Finally, the details of data analysis are outlined in section six.

Purpose

Although numerous authors address implementation procedures (e.g., Fixsen et al., 2005; W.C. Torrey et al., 2001), there is a lack of research on implementation of evidence-based practices in treatment settings (Corrigan et al., 2001; Goldman et al., 2001; Humphries, 2003; Shumway & Sentell, 2004). In addition, there are practices that have proven effective and efficacious in research (e.g., assertive community treatment, medication management approaches in psychiatry), yet numerous barriers have impeded implementation of these practices in the United States (e.g., fragmented mental health delivery system, the gap between the need for service and available funds).

The purpose of the current study was to generate a grounded theory of program implementation from the experiences of 6 Integrated Dual Disorder Treatment (IDDT) Team Leaders from community-based mental health agencies in Ohio who were charged with implementing the IDDT model and were working with the Ohio Substance Abuse

Mental Illness Coordinating Center of Excellence (SAMI CCOE). By focusing on these individuals' perceptions of implementation, the researcher gained an understanding of the process of implementation along with ways to better implement the model. The primary research question that guided the current study was: How do 6 IDDT Team Leaders in Ohio describe their experiences of implementing the IDDT model?

Design

According to Polkinghorne (2005), "Qualitative data are gathered primarily in the form of spoken or written language rather than in the form of numbers" (p. 137). Some of the strengths of qualitative research include the exploration of new areas; the development of hypotheses; discovering the meaning that people place on structures, events, and processes in their lives; and richness that can capture complexity (Miles & Huberman, 1994). Therefore, it is an inductive process that allows for exploration of a topic. Through the use of reflections and insights, the researcher explores the experiential life of participants. The reality of each participant in a study, including the researcher, is constructed, resulting in multiple realities (Creswell, 1998). Therefore, interpretation of the account (i.e., data) is subject to the researcher's own conceptualization (Strauss & Corbin, 1998).

Subjectivity is recognized and the researcher strives for objectivity throughout the study. For example, the researcher clarifies biases at the onset of the study to inform the reader of any potential influences on the study (Creswell, 1998). According to Strauss and Corbin (1998), it is not possible for either researcher or participants to be completely

free of bias. They recommended that researchers not take sayings or situations for granted and always question what is being said (Strauss & Corbin, 1998).

Qualitative researchers can use various strategies to maintain trustworthiness and credibility (Strauss & Corbin, 1998). For example, in member checks, the researcher takes "data, analyses, interpretations, and conclusions back to the participants so that they can judge the accuracy and credibility of the account" (Creswell, 1998, p. 203). Upon receipt of the data, participants are free to make any corrections or changes deemed necessary. According to Lincoln and Guba (1985), the member check "is the most crucial technique for establishing credibility" (p. 314).

Data triangulation is another method to establish credibility and is critically important to a naturalistic study (Lincoln & Guba, 1985). The basic concept of triangulation is to compare different sources, or independent measures, that agree with or do not contradict findings (Miles & Huberman, 1994). According to Lincoln and Guba (1985), "No single item of information (unless coming from an elite and unimpeachable source) should ever be given serious consideration unless it can be triangulated" (p. 283). Through the use of triangulation, multiple instances are viewed from different sources through the use of different methods (e.g., multiple interviews, memos, member checks; Miles & Huberman, 1994).

External audits are another strategy in which an external consultant or auditor assesses the process and product of the account for accuracy (Creswell, 1998). The external auditor should be an unbiased third party without a connection to the study (Creswell). According to Creswell, "The auditor examines whether or not the findings,

interpretations, and conclusions are supported by the data" (p. 203). Another example of a strategy to maintain trustworthiness is through the use of open-ended questioning during interviews, along with analysis of a word, phrase, or sentence during data analysis (Strauss & Corbin, 1998).

Qualitative researchers are "more interested in deriving universal statements of general social processes than statements of commonality between similar settings" (Bogdan & Biklen, 1998, p. 32). The researcher focuses on a situated study of behaviors and ideas and is not interested in replicating a study (L. Richards, 2002). Therefore, the researcher uses open-ended questioning to elicit the views of participants in order to generate theory. Overall, qualitative research focuses on gaining insight into and understanding about processes and concepts.

Creswell (1998) described five traditions of qualitative inquiry: ethnography, phenomenology, biography, case study, and grounded theory. Grounded theory was used in the current study for two reasons: (a) to discover or generate a substantive theory of implementation and (b) a substantive theory of implementation would contribute the most to the scholarly literature (Creswell, 1998). According to Rennie (1994), "The task set by grounded theorists is to understand and represent the meaning of information about human experience and behavior" (p. 429). Grounded theory is open-ended and is an inductive process in that the theory follows from data (Lincoln & Guba, 1985). The substantive theory emerges from and is grounded in the data and moves from the specific to the more general.

A purposive sampling strategy (Strauss & Corbin, 1998) is used to examine participants who can contribute to an evolving theory. Sampling of participants who can add to the topic of interest and emerging understanding evolves throughout the process (Strauss & Corbin). Strauss and Corbin stated that "each event sampled builds from and adds to previous data collection and analysis" (p. 203).

According to Patton (2002), "Grounded theory begins with basic description, moves to conceptual ordering . . . and then theorizing" (p. 490). Data are examined through open, axial, and selective coding, and each new source of data is compared with existing data. The end result of grounded theory inquiry is a substantive theory that provides a thick, rich description of respondent's constructions (Lincoln & Guba, 1985). With the use of thick, rich description, the reader is able to vicariously experience the world of participants. In sum, the method of data analysis in grounded theory is well formulated and described more concretely when compared with other traditions (e.g., phenomenology; Creswell, 1998; Miles & Huberman, 1994).

Participants

The current study was driven by a conceptual question and was not concerned with *representativeness* (Miles & Huberman, 1994). A purposive sample of IDDT Team Leaders who had direct experience with implementation was used in order to examine individuals who could contribute to the evolving theory of implementation.

The sample size for the current study was small and was set at 6 participants. According to Rennie (2006), "Depending on the uniformity of the phenomenon among its sources of information applied to it, saturation may occur in as few as six or so sources"

(p. 65). Because the focus of qualitative research is to study a few individuals in-depth and within their context (Miles & Huberman, 1994), the sample size was appropriate.

Prior to choosing participants, approval to use human research participants was obtained from the Institutional Review Board (IRB) at Kent State University. The approval form can be found in Appendix C. Three criteria were selected to determine eligibility to participate in the current study. The first criterion for participation was employment as the IDDT Team Leader for a community mental health agency in the state of Ohio. The IDDT Team Leaders were in the best position to answer questions about implementation because they were responsible for overseeing, monitoring, and increasing adherence to the 25 fidelity domains of the IDDT model. The second criterion was that the IDDT Team Leader and the agency were actively working with the SAMI CCOE. Identified earlier as a change agent, the SAMI CCOE assists agencies in the innovation-decision process, focuses on the adoption of new ideas, and continuously reinforces the decision to adopt an innovation. The SAMI CCOE actively works with agencies and IDDT Team Leaders to increase adherence to the model and offers numerous services (e.g., training, meetings) that help ease the transfer of research to practice.

The third criterion for participation was that the IDDT program needed to be in existence for at least one and a half years. The rationale for this criterion was that the SAMI CCOE would have completed a baseline and one-year review of the program. Therefore, the IDDT Team Leader would be in a good position to address challenges and facilitators to increasing adherence to fidelity.

Participants were selected from the SAMI CCOE website, which is available to any agency interested in implementing the IDDT Model. The website incorporates a program locator for agencies working with the SAMI CCOE and currently implementing the IDDT model throughout the state of Ohio. Search criteria on the SAMI CCOE website for the current study included all community-based mental health programs implementing the IDDT model. Inpatient facilities were not included in the search because the IDDT model and fidelity scale were modified for this setting, which would result in a heterogeneous sample. Thirty-two community mental health agencies throughout the state were listed on the program locator.

Through a process of elimination, 13 agencies were eliminated at the beginning. Eleven of the agencies on the program locator were new, the current researcher had been employed at an agency in Northeast Ohio, and one agency was eliminated after the IDDT Team Leader from that agency assisted the researcher in field testing the questions. From the remaining pool of 19 possible participants, 6 participants were randomly selected and asked to participate in the current study. The participants represented 4 regions within the state of Ohio in which the IDDT model had been implemented (i.e., Northwest, Northeast, Southwest, and Southeast Ohio). The initial intent was to interview at least one participant from each region; however, because of difficulty engaging participants, all 6 of the final participants worked in agencies located in one region of Ohio.

Of the 6 participants, 3 were female, 3 were male. Education consisted of at least a master's degree. All 6 participants held licenses: 5 of the 6 held independent licenses. Additional demographic information is presented in Table 10. Because of the small pool

of potential participants and in order to maintain anonymity, the names of the participants were changed to reflect names that were not gender specific.

Table 10

Demographic Information

Descriptor	Range
Age	31 – 59 years
Years of Experience in the Provision of Mental Health Services	6 – 28 years
Approximate Number of Employees at the Agency	50 – 200
Number of Years Agency Has Been Implementing Model	2 – 8
Approximate Number of Clients Served Annually at Agency	1,500 – 7,000
Number of Members on IDDT Team	7 – 14
Number of Clients on the IDDT Team	30 – 325
Scores From Most Recent Fidelity Reviews	
Organizational Characteristics	3.5 – 4.7 (Out of 5)
Treatment Characteristics	3.2 – 4.3 (Out of 5)

Procedure

Prior to contacting potential participants, the researcher met with an IDDT Team Leader in order to field test the questions. During this interview, the IDDT Team Leader was asked to provide feedback about the questions. Using this feedback, the researcher made changes to the questions that would enhance clarity during the interview process (e.g., rewording a question to avoid confusion).

After selecting 6 potential participants (i.e., IDDT Team Leaders) from agencies throughout the state, the researcher contacted them by electronic mail to briefly explain the purpose of the study, inquire about their willingness to participate, and obtain permission to call them on the telephone. The researcher maintained a Microsoft Word [computer program] document with each potential participant's name, address, telephone number, and email address on a computer disk. Within this document, each participant was given a unique participant code that was known only to the researcher.

Three of the 6 initial potential participants agreed to participate and 2 did not respond. One potential participant became angry and stated that she had already given a lot of time to research conducted by the Ohio SAMI CCOE. The morning of an interview with 1 of the 3 participants, the participant called the researcher to inform her that she had been told that morning that the agency was cutting back considerably on the IDDT program. The participant verbalized concern that the program would be cut all together.

Three agencies no longer had IDDT Team Leaders. The researcher then sent out 10 more emails to potential participants. One participant agreed to participate, 2 declined, and 7 did not respond. The researcher then went back to the Kent State University Institutional Review Board to modify the initial proposal and ask for permission to telephone potential participants to follow up on the initial emails. Permission to call prospective research participants was granted, and the researcher proceeded.

The researcher left messages with 3 potential participants. One potential participant returned the researcher's telephone call and agreed to participate. Two did not

respond. The researcher was able to directly contact 2 potential participants who agreed to participate.

During the initial telephone conversation, the researcher used a screening form (Appendix D) to determine whether participants met criteria for the study. Participants were asked the following questions: (a) are you currently working as the IDDT Team Leader in the organization, (b) are you and the agency actively working with the SAMI CCOE, and (c) has the IDDT program been in existence for at least one and a half years? Potential participants were also asked which days and times would be best for the researcher to contact them.

If the participant fulfilled criteria for the study, the participant code was placed on the screening form in order to maintain confidentiality throughout the study. Potential participants were informed about the scope and nature of the research, along with the benefits to them and the field, and invited to participate. They were informed that they would be asked to participate in two separate individual and in-person interviews that would last from one to two hours each and review transcripts for accuracy on their own time after each of the two interviews. They were also informed that they would be asked to talk with the researcher on the telephone at the conclusion of the study to provide feedback about preliminary themes. Potential participants were informed that they would receive a check for $20 after reviewing the transcript from each interview and after providing feedback about preliminary themes. Therefore, they had the opportunity to earn a total of $60 at the end of the study. Potential participants were informed that they would be given a participant code that would be used in order to protect confidentiality and were

also informed of their right to refuse to participate and withdraw from the current study at any time without incurring penalty.

Upon verbal agreement to participate, potential participants were sent a packet of information that included the consent to participate and audio tape form (Appendix E) and a demographic questionnaire (Appendix F). During data analysis, the demographic data were continuously compared to the data obtained from the individual interviews to explore how demographics may have influenced implementation. For example, would the Team Leader's licensure, years of experience in mental health treatment, training on the IDDT model, and number of years as an IDDT provider impact implementation? Or, how did agency size, including the number of staff and clients on the IDDT Team, and location (e.g., rural or urban) impact their experiences of implementation? A self-addressed stamped envelope was also included in the packet so that potential participants could return the consent to participate and audio tape form and the demographic questionnaire to the researcher.

Each interview was a conversation with a purpose (Lincoln & Guba, 1985). According to Lincoln and Guba:

> The purposes for doing an interview include, among others, obtaining here and now constructions of persons, events, activities, organizations, feelings motivations, claims, concerns and other entities; *reconstructions* of such entities as experienced in the past; *projections* of such entities as they are expected to be experienced in the future. . . . and verification, emendation, and extension of constructions developed by the inquirer. (p. 268)

Participants were given the choice of conducting the interview at his or her place of employment or in a neutral location. At the start of each interview, the researcher briefly introduced the topic of the study in order to familiarize participants with the study (Nelson et al., 2006). The interview protocol (see Table 11) was followed to ensure consistency across interviews.

The interview was structured in order to obtain information that focused on the themes of implementation, leadership style, and the transfer of knowledge to practice. Although the intent was to cover specific areas, flexibility during the first interviews was paramount in order to include information that would expand the evolving theory. Each interview was audio taped and transcribed by the researcher in order to ensure accuracy of data. The actual transcriptions of each interview were electronically stored on individual computer disks. The researcher maintained memos throughout each of the interviews (Lincoln & Guba, 1985) to gather information not captured on the audio recorder (e.g., body language, inflection of tone), and consider emerging themes. Most importantly, the memos assisted the researcher in maintaining an awareness of any distortions of data (e.g., biases, personal perceptions) that may have impacted the interview process (Lincoln & Guba, 1985). These memos were stored with the individual disks.

Each interview was transcribed by the researcher within one week and sent to participants via email. Participants were asked to review the transcripts for accuracy and make any corrections or changes deemed necessary (e.g., member check; Lincoln &

Table 11

Interview Protocol

Interview Question 1: How does an IDDT Team Leader implement the IDDT model?
a. Tell me about the history of your IDDT project.
Interview Question 2: How does the IDDT Team Leader's leadership style impact implementation?
a. How would you describe your role as Team Leader?
b. How, if at all, has your style assisted implementation?
c. How, if at all, has it impeded implementation?
Interview Question 3: How does the Team Leader transfer knowledge to practice?
a. What has it been like for you to transfer knowledge of the model into practice?
b. What was helpful in transferring knowledge to practice?
c. What was not helpful in the transfer of knowledge to practice?
d. Where are you currently succeeding?
e. What challenges have you encountered?
f. How have the challenges affected implementation?
g. What have been some things you have learned?
What comments or recommendations, if any, would you offer to the creators of the IDDT model?

Guba, 1985). Only 1 of the 6 participants made changes to the transcript, and the changes expanded on responses to questions. The remaining five transcripts were approved without change.

After receiving feedback on the accuracy of each transcription, the researcher created units of data with the use of index cards. The front of each card contained data from the interviews. The back of each card included the question being asked, the

paragraph on the transcription that the data could be found, the interview (i.e., first or second), and participant number. The researcher then coded and analyzed data and began developing categories and subcategories derived from the evolving theory in order to compare data that could be examined during subsequent interviews (Strauss & Corbin, 1998). The researcher analyzed data through the use of the constant comparative method wherein variations in emerging and grounded concepts were systematically examined and refined (Patton, 2002).

External Audit

After all of the first interviews were transcribed and prior to the final round of interviews, an external audit was performed by a doctoral level student who was neither connected to the study nor familiar with the IDDT model. According to Creswell (1998), "the auditor examines whether or not the findings, interpretations, and conclusions are supported by the data" (p. 203). The auditor reviewed the transcript from the first participant. In order to maintain confidentiality, the auditor was not given information about this or any other participant.

The auditor was asked to read through the transcript and look for emerging themes. The auditor and the researcher identified similar themes that included the use of motivational interviewing strategies that were incorporated into practice (e.g., using stage-wise interventions with clients, staff, administration and the community), taking on the role of Leader as motivator, and the importance of support during implementation (e.g., networking with other Team Leaders, staff at the SAMI CCOE).

The researcher also met with a dissertation committee member to discuss emerging themes. The committee member encouraged the researcher to explore themes of philosophical *fit* (e.g., how does the model's philosophy fit with the participant, team members, and agency). These themes were explored during the second round of interviews.

Second Interview

The researcher conducted second interviews with each of the 6 IDDT Team Leaders from the original sample in order to saturate, develop, and compress the initial categories (Strauss & Corbin, 1998). The researcher used a second protocol based on emerging themes from the first interview (See Appendix G). The researcher transcribed the second interviews within one week and electronically mailed each participant his or her respective transcript to check for accuracy and make any changes that they deemed necessary. Five of the 6 participants approved the transcriptions without making changes to the data. One participant provided additional information to enhance the interview and sent the corrected copy through electronic mail.

After all data were collected from both interviews, the researcher contacted all 6 participants by telephone to discuss interpretations and conclusions from the first and second interviews to establish credibility.

Data Triangulation

Data triangulation was used in this study to establish credibility. The data that was triangulated included the demographic questionnaire, two 1- to 2-hour interviews with

each of the 6 participants, researcher memos, member checks of each interview, and interpretations and conclusions from interviews.

Participant Retention

All 6 participants completed each of 2 interviews that lasted between 1 to 2 hours each. All 6 participants checked their respective transcripts and emailed any comments back to the researcher. All 6 participants talked with the researcher about interpretations and conclusions from the first and second interviews.

Data Storage

The individual disks, memos, screening form, and consent to participate and audio tape forms were stored in the Adult Counseling, Health and Vocational Education department at Kent State University for three years after completion of the research.

Assumptions

The researcher is currently a doctoral candidate in the Counselor Education program at Kent State University. She is dually licensed as a Professional Clinical Counselor Supervisor (PCCS) and a Licensed Independent Chemical Dependency Counselor (LICDC) by the state of Ohio and has experience implementing the IDDT model in both an in-patient state psychiatric hospital and an out-patient community mental health center in rural Ohio.

One assumption held by this researcher was that preparation, education, and readiness of the IDDT Team Leader were important factors prior to and during implementation. A second assumption was that various challenges would be present and difficult to overcome if agency administration did not endorse the IDDT model. Such

challenges included lack of funding, which would negatively impact various aspects of fidelity such as time-unlimited services and intensive staff training on the model.

In order to contain assumptions, the researcher adhered to the protocols during each interview. Questions used to prompt participants consisted of open-ended questions that would elicit their views and, as mentioned earlier, the researcher wrote memos during each of the interviews in order to maintain awareness of assumptions during the interview process. The researcher challenged any emerging themes that may have been based on these assumptions.

Data Analysis

In grounded theory, data are analyzed through the use of open, axial, and selective coding. In the current study, categories and subcategories of information were developed (through open coding; Creswell, 1998) by asking participants to describe their experiences of implementing the IDDT model. These categories and subcategories were then assembled in different ways in order to systematically develop and relate the categories to begin developing theory (i.e., axial coding) and then integrated (i.e., selective coding), culminating in a theoretical proposition or theory. Because the current study focused on the experiences of individuals who had implemented the IDDT model in the state of Ohio, a substantive theory about implementation was generated.

During open coding, raw data was inductively analyzed into categories in order to generate a working hypothesis (Lincoln & Guba, 1985). The researcher used index cards to *unitize* data (Lincoln & Guba) to develop provisional categories. Each card represented a unit of data that was situated within its own context. Open coding was used to form

"initial categories of information about the phenomenon being studied by segmenting information" (Creswell, 1998, p. 55). During open coding, the researcher looked for similarities and differences within the data written on the index cards. Data was "broken down into discrete parts, closely examined, and compared for similarities and differences" (Strauss & Corbin, 1998, p. 102) among dimensions and properties. In order to further specify a category, subcategories were developed to answer questions about and explain the phenomenon (e.g., where, why, when, how). For example, subcategories referred to consequences, conditions, or actions/interactions (Strauss & Corbin) that pertained to a category with an overall goal of gaining understanding of phenomena.

After developing categories from the initial interviews with open coding, a second interview protocol was created. The researcher returned to the field to densify, saturate, and develop the initial categories (Strauss & Corbin, 1998) through additional interviews. After transcribing the second interviews, completing a member check, and coding the data, the researcher used the constant comparative method (Strauss & Corbin) to compare data from the first and second interviews. This process continued until the categories were saturated and new information no longer added insight into existing categories (Creswell, 1998).

Axial coding was used to add depth and structure to a category. Coding was performed around the axis of a category, and categories and subcategories that were established during open coding were related (Strauss & Corbin, 1998) in order to develop a central phenomenon (Creswell, 1998). During this process, the researcher modified, merged, and deleted the index cards. The researcher created a spreadsheet in Microsoft

Excel in order to visually present both the process and structure of the evolving theory. The spreadsheet allowed the researcher to view data more closely and link process to structure. According to Strauss and Corbin (1998), "The purpose of axial coding is to begin the process of reassembling data that were fractured during open coding" (p. 124) in order to build theory.

With the use of selective coding, the researcher refined and integrated the major categories developed during axial coding to create one central category or theory (Komives, Owen, Longerbeam, Mainella, & Osteen, 2005). The researcher was responsible for interpretation and analysis of data and identification of themes that resulted in a thick, rich description of a substantive theory of implementation.

Summary

Chapter 2 focused on the methodology used in the current study. Due to the lack of research on implementation of evidence-based practices, a qualitative methodology was warranted. More specifically, a grounded theory methodology was chosen for the current study in order to discover or generate a substantive theory of implementation that could add to the research base. With the use of grounded theory, the researcher was able to explore the perceptions of IDDT Team Leaders on the process of implementing the IDDT model within the state of Ohio. The results of the current study were generated from these perceptions and are grounded in the data.

Within Chapter 2, the purpose and design of the current study were discussed. The participants chosen for the current study and the details of the procedures that were followed were described in this chapter. Finally, the researcher's assumptions about

implementation were clarified, and analysis of data used to generate a grounded theory was defined. In Chapter 3, the summary of findings for the current study that resulted from data analysis is presented.

CHAPTER III

RESULTS

In Chapter 3, a summary of findings is presented. The results for the current study are supported by data gathered through 2 separate individual, in-person interviews with 6 participants. In the first section, a brief description is given of the individuals who participated in the current study. In the second section, participants described how they implemented the Integrated Dual Disorder Treatment Model. According to the data, implementation was a multidimensional process that occurred simultaneously. Three processes emerged and are the themes within the current study: learning to be an IDDT Team Leader, learning about and embracing the IDDT model, and implementing the IDDT model. Data to support the themes were described in this section. In the third section, extraneous data that did not evolve into a theme but are noteworthy are presented. Throughout the process, the vision that pulled the Team Leaders forward was the long-term goal of providing good client care (see Figure 1).

Participants

All 6 participants held at least a master's degree and a license in a mental health field (i.e., clinical counseling, social work, chemical dependency counseling). Because of the small pool of potential participants and in order to maintain anonymity, the names of the participants were changed to reflect names that were not gender specific, and only general information is used to describe them.

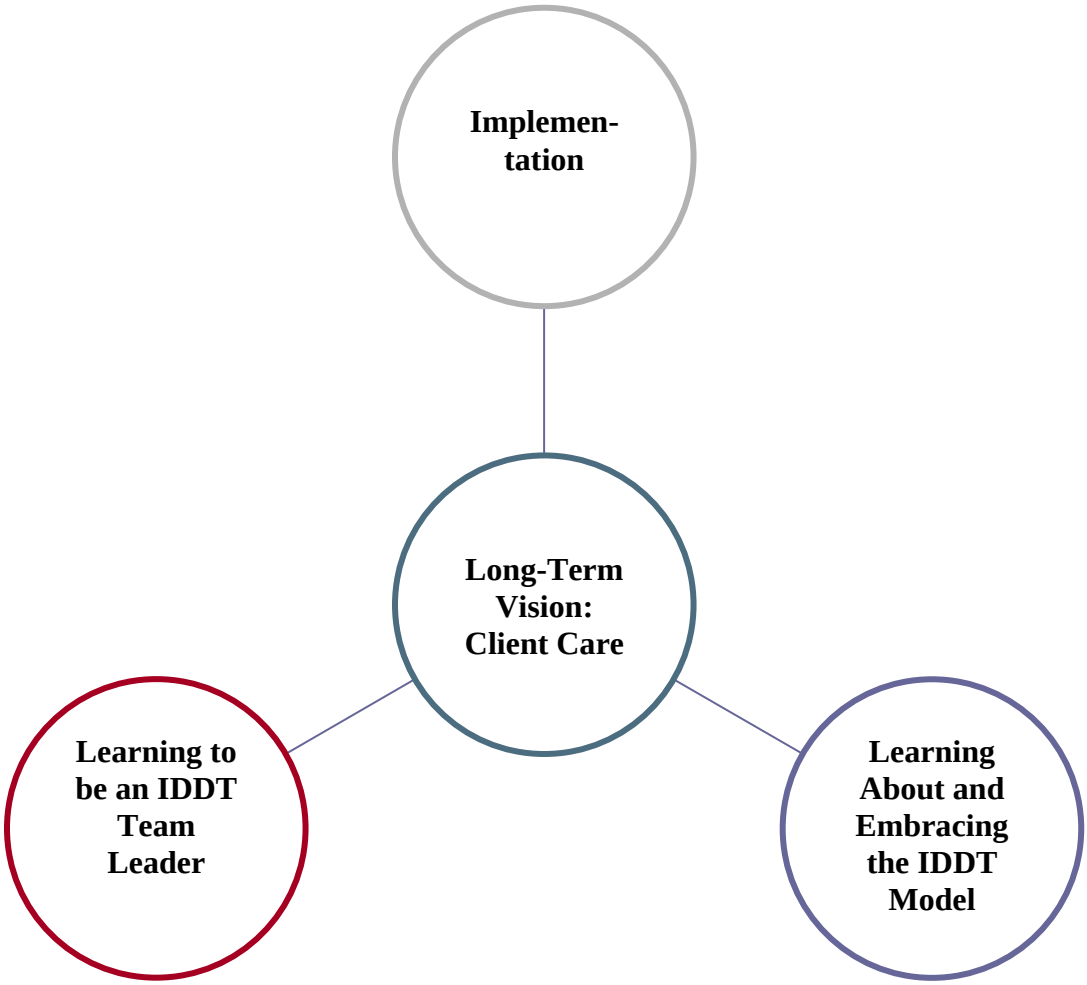

Figure 1. Implementation as a multidimensional process

Pat

Pat had over 15 years of experience in the provision of mental health services, and had worked at the current agency for most of the 15 years. Pat had a wide range of experience prior to taking on the role of Team Leader including, but not limited to, case management, intake specialist, therapist, and IDDT Team Member.

Chris

Chris had approximately nine years of experience in the provision of mental health services, and had worked at the current agency for six of the nine years. Chris also had a wide range of experience prior to taking on the role of Team Leader, including but not limited to, case management, therapist, and IDDT Team Member.

Terry

Terry had approximately six years of experience in the counseling field and had worked at the current agency for two years. Terry's prior work experience focused solely on chemical dependency. As a result, Terry was not familiar with integrated treatment prior to employment as the IDDT Team Leader. Terry's experience prior to taking on the role of Team Leader included individual and group chemical dependency counseling.

Casey

Casey had approximately 17 years of experience in the counseling field and had worked at the current agency for over four years. The majority of Casey's experience was in chemical dependency, and Casey was not familiar with integrated treatment prior to taking on the role of IDDT Team Leader. Prior to taking on the role of Team Leader, Casey had worked as a drug and alcohol counselor and as a case manager.

Sam

Sam had approximately 15 years of experience in the counseling field and had worked at the current agency for less than one year. Like Terry and Casey, the majority of Sam's experience was chemical dependency, and Sam was not familiar with integrated treatment prior to taking on the Team Leader role. Prior to taking on this role, Sam's experience included front line clinician and supervisor.

Bailey

Bailey had approximately 28 years of experience in the provision of mental health services and had been employed at the current agency for 20 of those years. Bailey's experience was unique because without formal knowledge of integrated treatment, Bailey advocated for integrating treatment when starting at the agency in the late 1980s. Bailey's experience included, but was not limited to, therapist and head of family therapy programming.

Learning to be an IDDT Team Leader

Each participant described how they were hired as the IDDT Team Leader at their respective agencies and reflected on the learning curve associated with a leadership position and being a part of a team in a leadership role. As they began their journeys, they realized that the process was not easy. In fact, the process was described as difficult at times. One area that was discussed by participants was the need to take on and balance various and different roles, or in the words of Terry, "I wear lots of hats." The participants also talked about learning to work within the framework of a team concept as both a servant leader and a team member.

Taking on the Role of Team Leader

Pat, Chris, Casey, and Bailey were on staff at their respective agencies and were approached to take on the role of IDDT Team Leader. Terry applied for a different job at the agency and was asked about willingness to take over as Team Leader. Sam applied for and was hired as the IDDT Team Leader.

Learning to be a Team Leader was wrought with various challenges and internal processes. Pat had been on the team prior to being promoted and reflected on taking on the role of Team Leader:

> It was horrible! It was horrible! Well, I think it was more difficult for me because I went from a peer to a leader role . . . into the leadership role. You know, just even the word or that thought that somebody has authority over you or something. I had a really hard time because I always felt like part of the team. And then, when I got promoted to team leader, I felt like I was not part of the team anymore. So, I had my own little process that I needed to go through. . . . I really had a hard time even exercising authority when I needed to and figuring out how to do that in the right way, I guess is the biggest thing for me.

Terry did not have supervision experience prior to becoming a Team Leader and had initially applied for another job in the agency. As Terry reflected on the process of becoming Team Leader, the process was described as "exciting," "a transition," "scary," "challenging," and "empowering." The team's response to Terry was different from the other team's responses to the participants. The team was described as "skeptical" and needed to be "sold" on the model. When asked about the process of becoming Team

Leader, the participants described a learning curve associated with taking on a supervisory role. Terry talked about taking over as IDDT Team Leader:

> It was hard. I had never been a supervisor before, so I didn't know what I was doing either as far as really, I just knew what I valued in past supervisors that I had, things I would want to do. So, it was a humungous growing curve the first year.

Sam was able to describe the learning curve associated with taking over the role of IDDT Team Leader:

> At times overwhelming because of the huge learning curve. . . . Learning a larger team of people, learning new programs that I had really not a lot of direct exposure to. . . . But it's also been, even though it has been overwhelming, it has been very exciting because it's been such a good match. I enjoy coming to work and this is the first time in a very long time that I could say that.

Casey was approached by the director of the agency to take on the role of Team Leader and stated, "I was excited because I was a case manager and I thought it would be good, especially a good experience for me to step outside of the box, because I was doing direct service for so long."

The participants were able to reflect on their internal processes and how they were able to gain a level of comfort in their role as Team Leader. Pat was able to realize unreasonable expectations placed on self as leader:

> I think I had to go back to: it's funny, because all the things that I talked about are things that I had to deal with myself. The whole humility thing. I needed to stop

> expecting that I would know what to tell these girls every time they walked into the office. I put that expectation on myself like I'm the supervisor now. I'm their go-to girl. If I don't know, I've failed. And so, I needed to kind of relax a little bit and work on that.

Pat described the self-evaluation process and the realization that the outcome of the program was the Team Leader's responsibility:

> I think doing it for a while. I think my competitiveness in a way of that this is going to be a good program while I am in charge of it . . . that's my responsibility. I want them to feel like they can come to me and talk to me, but if they don't like me on any given day, I'm okay with that. Because work is about what we put out and what we do for clients, so kind of doing that. Putting our client's benefit . . . making sure I understand it's the care that the clients get that's important at the end of the day. . . . I got out of the fact that it was about me. That this is about me and what kind of a leader I am and what kind of supervisor I am.

Terry described a similar process of self-evaluation and growth as a team leader:

> One of my struggles early on, which I've grown as a supervisor, is that I know that they don't always have to like me, and that's okay. Not everybody's going to like me. And probably my own issues of always trying to be a people pleaser.

Terry was able to identify growth and confidence as a supervisor. However, Terry was also able to identify an ongoing internal struggle with finding balance in holding team members accountable, stating "I don't like confrontation. I'd rather find an answer than write you up." Casey described the self-evaluation process as Team Leader: "Trial

and error. It's learning what I am as a leader and just offering just genuinely what I have."

Chris had been an IDDT team member prior to taking on the role of Team Leader and reflected on the response to moving into the Team Leader position:

> I had the background in IDDT. I was dedicated to the team. I was still under [*sic*] for supervision at that time while I was on the therapy team because they were going through some transition too. I was still treating dual diagnosis clients, so it just fit and they were looking for someone internally to take over. It was a good fit. I enjoyed therapy a great deal, but I had a love for the team and a love for the clients that we serve on this team. And I figured that I was young enough and could handle the stress that comes along with it and I can always do therapy the rest of my life. I could do therapy until I was 80 years old, but in terms of being the supervisor on a team like this that is this intense, it was a good move for me at the time. So, they interviewed me, and I decided to go with it.

Balancing Job Responsibilities

According to participants, the role of IDDT Team Leader carries numerous responsibilities, and flexibility and the ability to prioritize were extremely important. The Team Leaders were responsible for administrative tasks that included tracking member's productivity (i.e., the expected number of billable hours that the team member is meeting with clients), making sure that documentation was done correctly, and ensuring that clients were cared for (e.g., seen frequently by case managers, taking medication). The Team Leaders were also responsible for tasks that were inherent to the IDDT Model,

including being in charge of team meetings and directing the development of the program (e.g., measuring outcomes, adherence to fidelity). Terry and Bailey also provided counseling to the IDDT clients at their respective agencies.

The participants stated that at times, it was difficult to balance all of the duties and verbalized the need to prioritize. However, because of the population with whom they worked, the participants were able to acknowledge the need for flexibility in their days. Many times, their days were interrupted by client crises, and the plans that were laid for the day needed to be set aside. When asked to describe the role of Team Leader, Terry stated, "That's a hard question. . . . I wear lots of hats, which was hard to prioritize what hat I had to wear what day." The participants talked about the need to be flexible with time and treatment approach. Terry stated, "It's kind of our logo that you have to be completely structured and organize your day but be willing to throw it out the window and do something totally else." Terry added, "I feel very unbalanced! It's hard. I mean, it's really a challenge to do it all." Sam stated, "I really am struggling at times. I am not used to not having control over my day."

Casey reflected on the question of finding balance in the midst of numerous responsibilities and stated:

> I don't have a set time where I do this, this, and this. I don't have that. I prioritize what I need to get done. Some things I have to do, like I have to read the log every day, I have to respond to my boss every day about what goes on here. I have to read my emails every day and respond to my boss's boss every day, not every day, but when needed. So I balance by prioritizing and doing what needs to

> be done and then, I'm flexible enough to meet with the staff, just like he [staff member] just came in here [prior to interview]. It was unexpected, and I knew you were waiting, but just give him those minutes that he needed to talk. And so I balance by just doing it.

The participants appeared to accept that this was a part of their job and that client care was the priority. Pat stated, "I think my bottom line is it's about the clients that are here."

Learning to Work Within the Framework of a Team Concept

The participants described themselves as approachable and open to team members and maintained the stance that their job was to help team members. Even though they needed to hold certain expectations of team members (e.g., maintaining productivity), they were supportive and caring in their approach. Terry stated, "I try to empower them that they're just as important. Their opinions are just as important as mine."

Chris described the role of IDDT Team Leader as a *Servant leader*. When asked to expand and define characteristics of a servant leader, Chris responded,

> Respect for other people. Loving other people. Having compassion for where they are. Having an understanding and empathy for where they're at. I think it flies in the face of authoritarianism. . . . I think being humble is a big part of it. Being an active member of the team instead of being above the team. It's really like being below the team and supporting and helping them grow.

The importance of developing a relationship with the team was emphasized by Bailey:

> And you have to have a relationship with those people. Just not a boss type of relationship. You really have to care about those people. And then that will filter down to your clients because there's kind of a system you go down.

Not only did the Team Leaders serve the team, they also felt that they were a part of their respective teams and emphasized the importance of working together toward the common goal of client care. They talked about finding the balance between being in charge of the team and being a part of the team. Pat stated,

> My attitude is, look, we're all in this boat together, and so, you need to care about each other enough, while you're here, during this eight hours, to help each other out to do what's best for the clients. Because at the end of the day, that's the success. Its how did our team do with our clients?

Pat used this metaphor during both interviews to emphasize the importance of team work. Pat's focus was on creating an equal structure and making sure that a hierarchy was not established. For example, if there were problems between team members, the members were asked to communicate with each other and not ask Pat to resolve problems. Pat stated,

> It's just like a group facilitator. Understanding your role as a facilitator and not a group runner. I had to remind myself of that. . . . It's like, I've been doing groups forever, like, why would I not make the parallel? That I'm not responsible for fixing everything with all these people, that they need to go and handle it themselves.

Casey talked about the importance of communication:

> And you have to, working in a field such as this, to be able to talk about your frustrations, to talk about your shortcomings, and knowing that you don't know everything and you can't do everything and that kind of thing.

The participants talked about learning from their team members and maintaining the stance that they are willing to learn. Terry stated, "I jumped right in. I wasn't like I'm all that and you're not. It was very equal, like please teach me!" Terry talked about maintaining balance between administrative roles and being a part of the team:

> Held people more accountable, but then at the same time, kind of created more of a team environment that we're in this together. It's not your responsibility solely or mine. If we go down, we all go down.

Chris also talked about finding a balance and added, "I firmly believe that the supervisor/ Team Leader is not there to be the authoritarian and hold things in check." Sam talked about including the team in any decisions that would involve the team:

> Any changes that I am implementing, getting the team's feedback, because that was what they wanted [when they hired me]. They didn't want somebody coming in here making unilateral decisions. It goes against me, it goes against the model anyway, and it goes against a team philosophy. . . . I don't enforce changes. I don't say, "You need to do this," because I'm not the one who has to deal with the consequences afterwards.

Learning About and Embracing the IDDT Model

Not only did the participants need to learn how to be an IDDT Team Leader but also they needed to learn about the model. The participants talked about their reaction to

the model and how it resonated with their personal beliefs. The participants had verbalized a sense of frustration during the first round of interviews. When asked to reflect on these feelings during the second interviews, the participants recognized that they were not applying IDDT concepts to practice. As the participants reflected on their leadership styles, they described characteristics that were compatible with the IDDT Model. The synthesis of the IDDT Model with their personal style was evident in their application of concepts in interaction with staff.

Learning About the IDDT Model

Each participant came into the job from various perspectives. The participants described their reaction to the model and the focus on integrated treatment. Terry, Casey, and Sam had backgrounds in chemical dependency treatment and Pat's background was in mental health. Chris and Bailey were the only two participants who were familiar with integrated treatment. Terry stated, "I had no knowledge of IDDT prior to coming here other than what I prepped for my interview." During the first interview, Casey reflected on the response to the model:

> When it first came aboard two years ago, our director was really excited because it was evidence-based. And he came to us. This is when I was still a case manager. And he said that he wanted to adopt this model, and it was evidence-based. And he was trying to see who was excited about evidence-based treatment. And, he said, "It's kind of meeting the client where they are at and just building a rapport." And he was explaining it to us, and he was really excited about it. And, I've always been the type of person that agreed that the relationship was the most

important part of helping somebody. If they don't have a relationship with you, they don't trust you, they don't know you, then it's hard to work with people. So, I got excited about that.

Pat's background was in mental health treatment. Pat was approached by the IDDT Team Leader to be a part of the team and added:

Originally I had said that I didn't want to work with the chemical dependency sort of thing and then, it was just interesting to me. You know, the whole concept and the different thought process about how to deal with them [chemical dependency and mental illness] both at the same time instead of one versus the other. And, it was very much appealing to me in that you treated them like people, you know, you talk to them like people. It was just a little different from the old kind of way of doing things.

Embracing the IDDT Model

Participants described the IDDT model as empowering, exciting, flexible, freeing, difficult, validating, and a perfect fit or match. The model created a structure that provided solid direction for treatment. The participants stated that they had seen changes in clients over time and verbalized an appreciation of the model.

The participants talked about reduced staff burn-out as a result of working within the model. By having realistic or stage-wise expectations of clients, treatment is placed into the hands of the clients. For example, if a client wants to continue using substances, the clinician does not demand that the client maintain abstinence. Pat talked about the need to set goals with clients and to make sure that goals are manageable:

> I think that when you hold onto an expectation of a client that's outside of what they are capable of, everybody is going to feel like a failure. . . . It just helps because then they see them not for this resistant client who doesn't want help but they see them as a person who just doesn't know how to get the help that they need or accept the help that they need. So, I just think in that sense, I think that for the therapist it helps them not feel as much of a failure.

Casey talked about being client-centered and added,

> I've learned as a clinician that it's not on me per se when a person uses, and that's what the model has given me. What is on me is to continue to do what I do day by day. And hopefully one day when the client is ready, they get sober.

Chris stated, "I think most of the things that the model calls for really help make treatment easier, and it's something that the clinicians see works. They can see results." The participants reflected on how they would want to be treated if they were the client. Casey talked about how the model focused on meeting basic needs (e.g., housing, food) as a part of overall treatment:

> It was like, I just thought about me. If I didn't have a place to live, if I didn't know where I was going to sleep day to day and somebody tells me, "get sober," how can I do that? If all I'm around are people that are using, or I'm trying to mask my feelings or whatever.

Pat talked about meeting clients where they are in their own stage of treatment and how the model made sense:

> I just think it's who I am to be honest with you. It's how I've been since I was a kid. I wanted to help people and I wanted to do what they needed. Not necessarily what I thought. . . . So, for me, it almost validated how I was in general.

Terry also talked about how the model was a good fit and stated, "I think it fits perfect or near perfect. It fits very well." Chris talked about having a laid back approach to treatment and how motivational interviewing and the philosophy of the model was a good fit because it focused on the provision of treatment "at the other person's pace, respecting the person." Bailey talked about being a positive person and felt that the model looks at positive things and added, "I think that the advantages to the model basically are it stages people and it makes you accept the people where they are at, not where you want them to be."

Pat and Terry talked about the flexibility of the model and tailoring treatment to client needs. For example, clients are not expected to come into the office for treatment. If a client is struggling with trust or paranoia, staff goes into the community and provides treatment on the client's terms. For example, if the client is more comfortable talking with a counselor on a park bench, then the counselor does not expect the client to come into the agency for counseling. Bailey talked about how traditional programs would kick a client out of treatment if the client used substances or ban the client from treatment for a period of time. Bailey verbalized appreciation of the model in that clinicians did not hold expectations of abstinence and if a client used substances, the client could continue in the program without penalty.

Terry and Chris talked about the excitement of watching the model work in practice and the sense of empowerment that goes with practicing treatment that works. Chris stated,

> Oh, it's everything. My work wouldn't be worth doing if I couldn't see it come to fruition in what we do with clients every day. And being able to use it, and also watching clinicians use it and seeing it work with clients. It's everything. It's enormous. It's also very difficult. Its one thing to learn something and know it: book knowledge. It's an entirely different thing to sit down in the heat of the moment with a client and be able to use motivational interviewing when they're screaming and yelling at you. So, it's one of the most difficult things that we do, but it's one of the most rewarding.

Sam talked about believing in the model and the excitement of being in charge of implementation:

> I believe in what we are doing is making a difference for our clients and I believe in the potential that this program and this agency has and that to be a part of that is really cool. And for me to potentially be an influence of that change, to be a part of that change, potentially evoke that change, similar to what a therapist would do with a client, now just to do it on a larger is exciting.

Learning to Practice What You Preach

During the first interviews, participants verbalized a sense of frustration about the progress of the program, the progress of staff working within the model, and staff resistance to working within the model. When the sense of frustration was explored

during the second interviews, the participants recognized that the frustration was part of the change process. They also recognized the need to continuously focus on the concepts of the IDDT Model.

During the first round of interviews, Bailey expressed feelings of frustration about the progress of the program:

> I think that in the early beginnings, I expected things to fall into place easily. I'm one of those people, again, because I think I am positive, I expect things just to work and when they didn't work, I became extremely frustrated.

Pat discussed initial feelings of frustration towards the team because the team was not working within the model and stated,

> One other part of me is that I like things to be done right. I believe in it so much that when we're not doing it that way, I start to get discouraged and I'll get, you know. I think that one of the things that I struggle with is to stay that way with them is that they're at different places and I need to help them. I fall into the same thing that they do with clients.

Sam reflected on staff resistance to working within the model and added,

> It's difficult. It's kind of like when you are working with a client and you see what potential they have and you want to push them through the door and say, "If you just do this, I know things will be better." But they won't do it because of the resistance. But it can be frustrating in that this program has so much potential but . . . there's a lot of stuff that needs to be cleaned up first. And, you can't build unless you have a good solid foundation.

The sense of frustration was explored during the second interviews, and participants were asked to reflect on statements of frustration that were verbalized during the first round of interviews. The participants appeared to recognize the frustration as an internal process or lack of knowledge on the part of staff or self about the model and using the principles within the model. For example, Terry verbalized the recognition that staff was not in the same stage of change: "I'm ready to implement. I'm in action, and they're in precontemplation. . . . So, just, sometimes, I think I'm just ahead of them. I'm just ready to start doing some things and they're not." Sam recognized the need to apply the principles of the model in interactions with staff and maintain awareness of team member's stage of change: "The frustrations were the fact that I really wasn't implementing: I wasn't practicing what I preached. . . . So, a lot of the stress and frustration was self imposed." Sam gave an example of applying principles to practice:

> I need to do a better job of developing the discrepancies. . . . What they say that they want versus what they actually do. . . . That they want to be the best and they want things to be easier for them, but yet, when things are offered, they don't follow through.

Chris processed the question about frustration different and offered the following perspective:

> Well, I think to a certain extent I don't know that I would call it frustrating. Change is difficult, so learning something new is difficult and if there was anything that was tough implementing the model, it was just adapting things, getting off what you're used to and what's normal and what's comfortable and

making a change for the better. For the good of the team, for the good of yourself personally, the good of others, the good of the clients, the good of the agency.

Developing a Leadership Style That is Compatible With the IDDT Model

During the interviews, participants were asked to describe their role as Team Leader. The characteristics used to describe their leadership style resonated with the model. The participants described themselves as a motivator, role model, supportive, flexible, positive, strength minded, and stage minded. The participants incorporated concepts of the IDDT Model into their interactions with team members and administrative staff. They talked about educating and motivating team members in their everyday practice. They also talked about maintaining an awareness of which stage of change team members are in and meeting team members within their own stage of change during interaction.

Continuously Educating the Team About the IDDT Model

The participants verbalized the need to continuously educate staff about the model. According to Chris, one of the Team Leader's roles is to continuously maintain focus on the model in order to "stay fresh" and not become stagnant. The participants were flexible in their teaching styles and applied various methods.

When asked to describe the role of Team Leader, Pat responded, "Modeler of appropriate behavior and attitude." Raising self-awareness was another method that Pat used with staff. Pat stressed the importance of increasing confidence in team members and maintaining a supportive stance during their learning process:

> In helping to support them, help guide them to what the next step is. You know, what is it that you don't feel that you understand, and how can we, what can we expose you to education wise or job wise that will help you understand?

Chris also talked about the importance of being supportive with staff and helping team members feel autonomous and capable of excelling in their work. Chris verbalized the desire to:

> allow them to be the clinicians they need to be. I expect them to be excellent in their work. I don't sit over their shoulder and make sure they do everything perfectly. . . . [however] If things are going down a path that is not healthy for the client or for themselves, then we'll sit down and talk about that. But it's never in a way like, you're in trouble. You're not doing this right. It's more like, you can do this, I know you can do this. What can we do to improve? What can we do to make it better?

Sam used an in vivo process of "mirroring what the IDDT model is," or taking the concepts of the model and applying them with staff in order to educate them about the model. Terry used team meetings to formally teach the team about the principles of the model: "We talk a lot about IDDT basics, principles. I think everybody learning the stages, really understanding the stages of treatment, the appropriate interventions for the stages."

Motivating the Team

The participants described themselves as motivators and were able to recognize this aspect of self prior to joining the team. They discussed the difficulties inherent in

working with a challenging population (i.e., IDDT clients) and the importance of continuously motivating team members so they do not become discouraged. Each participant described the unique ways that they motivated their teams.

When asked to describe their role as Team Leader, Pat and Terry both described themselves as their team's cheerleader. Terry stated, "I like to think of myself as my team's number one cheerleader. I'm their advocate, I'm their backup, I'm their coach." When asked the question "What prompted you to join the team," Terry stated, "I've always known that I do have leadership skills. I can rally the troups kind of personality, so I just knew that I wanted to move up the proverbial ladder or whatever."

Casey was asked to be the Team Leader. When asked, "How did you come to be an IDDT Team Leader," Casey responded:

> I think I had the background, and I had the leadership abilities, and I had the type of style, I think, that really engages people. Not only the clients, but can motivate a team and engage a team of people.

Pat talked about working with clinicians so that they do not get discouraged in their work with the IDDT clients. Pat's focus was on developing different perspectives for the clinicians so that clinicians did not feel responsible for what a client is doing:

> What I try to do is I use a lot of motivational interviewing, a lot of open-ended questions and I use a lot of metaphors with them when I supervise. . . . I try to get them in their [client's] world a little bit more. You know, and saying maybe their medicine's not working, or maybe she's [client] having a bad day and all sorts of triggers are happening. You know, the holidays are coming and her dad is coming

> and her dad is the one who molested her. . . . You know, to see them [clients] for how complex they are.

Casey talked about the need to motivate team members when they become discouraged and help them understand that recovery is a long process:

> We have to continue to look at small successes. We have to continue to be able to vent when we get frustrated, when you see a client get sober and then they use. You've got to be able to openly talk and share in a team approach, and it is a team approach. It can get very demanding. So, my role is just to continue to motivate the staff to know that this is part of the process. That we're not going to get anything huge, and we have to really appreciate when a client comes and says, "I didn't use today."

Chris focused on motivating the team to continue striving to provide better services for the clients:

> It's important to keep us changing a little bit at least to better ourselves and keeping that attitude that we can always learn and we can always do better and there are people out there that know more than us and hope to continue that attitude to improve our services.

Working Within Stages of Change

The participants described a parallel process of applying the stages of change model not only to clients, but also to team members and administration. They took the time to know team members and gain an understanding of each member's stage of change along with their strengths and passion. Chris talked about having compassion,

understanding, and empathy for where the team members were in their change process, adding, "And I allow them to be the clinicians that they need to be." Casey's focus was on finding the good in each team member and building on their strengths. Terry talked about applying the stages of change with staff: "I've learned how to really try to treat each of my staff differently just like my clients. Each are in different places, have different needs."

The participants talked about spending time with team members in order to gain an understanding of their needs as clinicians and allowed them to structure the provision of treatment. For example, Pat worked with a team member who did not enjoy facilitating groups. After talking with the team member, Pat realized that the member was not comfortable with the existing format of the group and allowed this team member to pick the structure of a group. Pat added, "And, if at all possible, some of the things they don't want to do if they don't have to do that, try not to have them do it." Describing the role of Team Leader, Pat stated,

> I see myself as having to look at them stage-wise also in order for the team to grow and progress. And, so I think first and foremost, it's to support them in what they're trying to do and to help them be self aware of where they are in their own professional career and understanding of dual diagnosis and that.

When asked, "What have been some things you have learned," Terry stated,

> I guess that as far as stages of treatment goes, stages of change, they apply to all of us and that sometimes I need to apply some of those same skills to my team as

> I do to my staff as I do to the administration. As, where are they and what works best. Whether I need to roll with it or be more direct or information giving.

Sam talked about meeting staff within their own stage of change and the need for flexibility. Sam talked about a situation with a team member where flexibility was paramount in order keep the member at the agency: "Just like IDDT does with the clients. You adapt to what is going on." Throughout both interviews, Sam stressed the importance of working with the team and asking for feedback, especially if any changes were to be made:

> If I try to develop the program too quick, they're not going to be ready for it. If we try to make too many changes too fast without having some stabilization, it won't succeed. If you add too much too quick or make changes too quick, you can actually do more harm than good. You can destabilize something that is working. And because of ripple effects, a change that you make here could have unintended results completely in another different area that despite your best planning, you wouldn't have imagined.

When asked about striking a balance between the different roles as Team Leader, Chris calmly responded,

> I think the model, that's what the model does. It brings everything under staging. You can stage everything. That's what motivational interviewing does, too. You just stage what you do, so there are ties to helping clients recover and helping staff move forward and grow professionally and helping agencies or supporting agencies to adopt evidence-based practice and to change, and change is the same

> no matter what you're doing. . . . That idea really comes from the CCOE and their perspective on staging. They stage the agencies they work with just like we stage clients. That's not my idea, but I can kind of look back now and say, yeah, that's what I was doing. That was a perspective that I was taking.

Implementing the IDDT Model

The participants reflected on the implementation process and were able to identify both facilitators and challenges during implementation. As the participants reflected on what was helpful during implementation, they reflected not only on the changes that they made to create structure within their respective programs but also on the need to build a strong cohesive team comprised of individuals with specific characteristics. The participants identified the Ohio SAMI CCOE and administrative support as external factors that eased implementation. They were also able to identify challenges during implementation that included funding, changing thinking, staff turnover, state expectations, and fidelity items. Although the challenges appeared to slow down the process of implementation, the participants looked beyond the challenges and continued to maintain the long-term focus of client care.

Making Changes to the Program to Build a Solid Structure

The participants talked about the various changes that they made after taking on the role of Team Leader. Their focus was on adhering to the model and getting staff buy-in so that the team could move forward as a whole to provide good care to clients. The participants focused on creating structure within the program, specifically creating structure within the team.

During the second round of interviews, the participants were asked about specific changes that they made after taking on the Team Leader role. Pat reflected on this question and responded:

> I took our direction to quadrant four completely instead of quadrant three. That was a big thing with me. Myself, I don't know exactly how to say it. I brought them on board more about things. So, instead of kind of having—I tried to explain why things work and how they work and that sort of thing. Like with productivity and stuff, that's always a challenge for everybody. But, I would explain to them why productivity is a concern for them. The same thing with specific things about the model. With assertive outreach and they would get frustrated. "You know, how many times can I go to this person's house? What can I do"? And I said, "Well, what did you do? Did you just go"? And they're like, "Yeah." And I said, "Well, why don't you leave a hand written note next time. Maybe they're afraid to call us because they haven't talked with us for three weeks and they're used to people being mad at them when they disappear." Like, "Leave a nice note just to extend it to mean something to them." I guess is what my big focus was to try to get them invested in the clients and not just this is their job.

After taking on the Team Leader role, Terry made changes that focused on structure within the team and working together as a team towards a common goal. Terry stated:

> Much more organized and when people had psychiatric appointments, really instilling the importance of that appointment for all of us, not just the doctor and

> client, but for all of us, because if the clients are being seen by the doctor, they have a better chance of staying on track with their meds. Held people more accountable, but then at the same time, kind of created more of a team environment that we're in this together. It's not your responsibility solely or mine. If we go down, we all go down.

The participants talked about establishing set times for team meetings and holding team members accountable for attending the meetings. They also talked about establishing structure within the team meetings in order to use the time effectively. Team meetings were structured to include education about the model, direction of the program, discussion of client needs, and client progress (i.e., stage of treatment). Each participant talked about integrating ongoing training about the model into team meetings.

Bailey stated that attempting to create structure was a difficult process at first because there was an overall lack of structure. Staff members were accustomed to scheduling their work days around client needs (e.g., doctor appointments, appointments with Social Security Administration) and did not attend meetings regularly. Bailey stated that over a period of time, staff began to appreciate the team meetings:

> The people [team members] are really cooperating and its seeming like they like the meeting, which is a big thing. And, they're seeing that there's [*sic*] accomplishments being done. So, that took care of itself. Everybody's starting to get with the meetings and like them and see how it is saving them time and effort and they like it.

Chris and Sam talked about developing a supervision form to document what was discussed and to maintain focus during meetings. Sam added,

> And there was really no documentation of those meetings. So, I set up a format that we review high risk, high need cases first. We review any cases that need consultation with the psychiatrists, and then we do the quarterly 90-day reviews after that. And then, I keep a notebook and I take notes during that meeting so that we have a record of what we discussed, what's going to happen with the cases that are reviewed, so that if we ever need to, we have something to go back on.

Finding the Right Team Members

The number of team members on the various IDDT Teams ranged from 7 to 13. Team members included therapists, case managers, registered nurses, and psychiatrists. Each team had gone through various transitions since inception. Chris stated, "The growth of the team historically has waxed and waned in terms of the clinicians that we've had on the team." The participants reflected on how team members impacted implementation. They talked about past team members who were negative or had difficulty accepting the model and eventually left the team. Bailey stated,

> The attitudes with the staff are more positive. And I had some staff members that were not real positive about that. They left, especially one in particular. I had a staff who was basically very drug and alcohol oriented. You know, get them sober, get them clean. And the model was tough for them to accept. So, I've been able to move a couple of them more towards the one way and it's starting to work out very well for us.

Terry also talked about past team members: "We had a few members who are gone now that were just too negative. That pessimism was like a venom that just kind of oozed everywhere."

Despite changes on the teams, the participants talked about the strengths of the current team members and the overall stability that the team was experiencing. According to the participants, the team members had many years of experience combined and were able to bring this experience and knowledge to the team. Terry reflected on the current IDDT team at the agency: "I have some very strong personalities too. And we're very diverse racially, culturally, education wise. We're just very diverse. We come from all different backgrounds and we kind of like compliment each other."

In Order to be an IDDT Team Member You Either Have it or You Don't

The participants talked about the importance of having the right type of person on the team. The comments, *They either get it or they don't*, *You either have it or you don't*, and *That's the people who get the IDDT model* were verbalized by three participants. Sam stated,

> I think it's just the type of person that is drawn to this type of work. They either get it or they don't. I mean, you can teach someone about IDDT, you can teach someone about chemical dependency or mental illness, but you can't teach compassionate care. . . . And the very first step is you've got to have the right person in the right position. And I think that's what this team does. And maybe that's why IDDT is so successful, is that you're getting the right people in the

> right positions from the get go. You're laying the foundation to being good, and then you go from there to become great.

The participants talked about the difference between learning the model and applying it to practice. Pat stated, "And I think you can learn the model and you can learn the skills, but you either have it or you don't in terms of being successful." Bailey attributed a belief in the model and a desire to see it work to successful programs.

According to the participants, they actively looked for certain individuals to fill vacant positions on the team. Terry talked about the learning process involved in finding the right team members:

> I've grown a lot too, from just filling the position to there are personality characteristics I'm looking for more than what degree do you have. I need to know, are you going to be able to roll with it, are you optimistic, do you have hope? Those are integral. Those are so important.

The participants talked about the different characteristics that they look for in a team member. First and foremost, they looked for an individual who could work with a team. Pat stated,

> The ability to work as a team and kind of, there's really no room for lone rangers on a dual team like this, there's just not. If you are going to go off and do what you want to do, you're not going to work, and the clients are not going to benefit as much.

Chris and Sam talked about finding team members who worked well within a multidisciplinary team. Sam added,

> Someone who is definitely a team player who is going to support others when they need it to ensure that they are going to get the support when they need it. Somebody who is not interested in being the star, but being one of the stars.

Pat talked about how the team members work together and even though they may not like each other on a personal level, they would "have each other's back" if they needed help within the program.

Participants looked for team members who were empathic, caring, and compassionate with a desire to help others. Pat stated,

> I think you have to have a heart for these kinds of people. . . . I think you have to have a heart to understand who these people are and how broken they are and that it's not their fault. And I think if you don't or don't have the capacity or willingness to think about that, I don't think that you're right for the team.

Chris also focused on individuals who had a heart for the population and stated, "Empathy towards the population. Because I don't think you can teach that. I think it's something that's either there or not there." Chris also looked for individuals who were "laid back, client choice oriented, client goal oriented, consumer oriented," and added, "People who are more direct and have in mind what they want the client to do with treatment tend to have a tougher time with it." Sam talked about looking for individuals who wanted to make a difference.

The participants talked about the need for team members to be flexible with treatment approach. Participants talked about the need for staff to "think outside the box" and be willing to change. Sam talked about the need to be flexible in treatment approach

and tailor treatment to the client's needs: "Someone who is flexible and adaptable and not locked into 'Oh, this is the way it has always been done.' Somebody who is at least open to change, open to doing things differently."

Humility was another characteristic that the participants looked for in team members. According to the participants, team members needed to be open to feedback and criticism and be willing to admit that they are wrong. Chris talked about the need to find a team member who can accept criticism and not react:

> Because there is a lot of stuff that you have to change your thinking about when you implement IDDT. And if you're not willing to change what you're doing or not willing to hear any criticism, then it's not going to work for you.

Another aspect of humility that Terry discussed was the need for team members to have a willingness to get dirty:

> Like, actually dirty. I mean, we're in some really dirty places, houses, apartments. . . . A willingness to not say "I'm too good to do that," that if I need to help someone clean a refrigerator out, I need to help somebody clean a refrigerator out and not say, "I didn't go to college to clean a refrigerator out."

Another characteristic that the participants looked for was optimism or hope. They talked about finding staff members who focused on the positive and looked for strengths in the clients, maintaining hope that the client can change. Bailey talked about the importance of finding staff that works towards the client's best interests: "You try to hire people who are high energy, motivated people who are positive in nature. Actually,

this is what I think is one of the key things in the program. Not my program, but any program."

Pat talked about finding staff that was "up for the challenge" and succinctly ended the first interview with the following statement:

> I think if you don't believe in it [IDDT], it would be hard to do. It's an uphill sort of a thing. So, if you don't see it as worthwhile, who would want to walk up a hill all the time? You know, like, you could always look for something easier. But, this is certainly not for the faint hearted these folks. And I've got the right people on my team, they just don't know it sometimes, but they will.

Working With The Ohio Substance Abuse Mental Illness Coordinating Center of Excellence

The participants stated that the Ohio Substance Abuse Mental Illness Coordinating Center of Excellence (SAMI CCOE) conferences and regional meetings were helpful in the implementation process. SAMI CCOE staff was mentioned numerous times during the interviews and was perceived as extremely helpful and supportive during the implementation process. In the demographic questionnaire, all 6 participants stated that the *SAMI Matters* newsletter and the SAMI CCOE website were helpful; however, during the interviews, only 1 participant mentioned the website.

The participants talked about the importance of the SAMI CCOE conferences. Pat and Terry stated that they had attended a SAMI CCOE conference early in their implementation process and were able to learn a great deal about the various components of the model. Terry stated, "So much of the learning I got initially was, like I said, I was

fortunate enough to go to that conference right away." Chris stated that the manuals from the CCOE conferences were good reference tools during the early phase of implementation. Terry talked about the importance of networking with other IDDT teams:

> The SAMI CCOE conference in my dream world, we would close and we would go. We would get visiting nurses to monitor medication those weeks. . . . We would all go down as a team and do our own little whatever . . . I don't think we could afford it. But all of us to go. I would love every one of us to go. Be in a hotel room; be able to go out shopping. Have some fun, learn, meet other people, network. Network I think is so invaluable.

Sam talked about giving the team members an opportunity to see what the other IDDT teams were doing:

> They can see some of the other strong teams and realize that yeah, you guys are good, but there are some things we need to do to be better. Again because I don't know how much a basis of comparison they have to other teams.

The SAMI CCOE coordinates regional (e.g., Northeast Ohio, Central Ohio) meetings on a periodic basis. The participants talked about how these meetings were helpful in networking with other IDDT team members, hearing about services that other agencies provide, and sharing materials (e.g., staging tools). Terry stated,

> And I think becoming involved in those regional meetings is priceless. I think every Team Leader needs to be involved in those because it's a great place to hear what other people are doing, validate what you're doing, get new ideas, get some

> support, bitch a little bit, whatever. Feel like you're not in it alone you're not the only one doing this. You know, how they advocate things they want on their teams. Not feeling like I'm another Team Leader at [agency], but that I'm an IDDT Team Leader.

SAMI CCOE staff was mentioned numerous times during the interviews. The participants felt appreciated, respected, supported, valued, and encouraged by SAMI CCOE staff. According to the participants, CCOE staff provided various resources (e.g., progress summaries to use with clients) to ease the implementation process and linked IDDT Team Leaders with Team Leaders at other agencies in order to establish a network. According to the participants, SAMI CCOE staff is willing to come to IDDT team meetings at different agencies to work with team members, provide presentations, role play, or "sit back and listen." Casey reflected on how the SAMI CCOE staff was helpful: "Especially early on when we had someone from the SAMI CCOE come in, sit in our team meetings, and helping us with interventions to use with clients."

SAMI CCOE staff was perceived as a good resource for the participants and was available for consultation. Pat reflected on the value of being able to talk with an individual outside of the organization without worrying about penalties (e.g., disciplinary action, funding cuts):

> I think he [SAMI CCOE staff] has good ideas. You know, he helps give me a new perspective on things to try and it's somebody that their role not having a punitive sort of thing. You know, like, if I call him and say, "Nobody is using motivational interviewing and I don't know what to do." I don't have to worry about it

> affecting our funding. I don't have to worry about coming back to my supervisor and saying "Do you know that your girls are calling me saying they don't know what they're doing." You know, that it's a supportive role. There's no negative attachment to it. It's somewhere that I can go and kind of be honest about the weaknesses and get good feedback from people.

On the demographic questionnaire that was sent to each participant prior to the first interviews, all 6 participants wrote that both the *SAMI Matters* newsletter and the SAMI CCOE website were helpful for their ongoing practice. However, during the interviews, Sam was the only participant who referred to the website as a resource that was helpful in transferring knowledge to practice, adding, "obviously, going to the website and reading through all their materials and brochures."

According to what the participants wrote on the demographic questionnaire, the *SAMI Matters* newsletter kept them informed about what other agencies were doing and kept them up to date on matters related to IDDT (e.g., progress with the SAMI CCOE, medication, latest changes). The SAMI CCOE website was perceived as helpful to participants because it listed training events, allowed access to other IDDT professionals (i.e., linkage), and provided resource materials (e.g., group curriculum).

Compatibility of the IDDT Model With the Philosophy of the Agency and Administration

According to 5 of the 6 participants, the model was a good fit with the agency because both (i.e., model and agency) were client focused and client needs were paramount. Pat talked about how administrative staff sought an individual who could successfully construct and implement the IDDT model and added,

> I think the model fits directly with the agency and then takes it one step further. Being that we've always been client centered, what does the client want? What do they need? We don't force clients to have treatment they don't want to have. . . . I think the agency itself has always been like, "We want to do what the client wants us to do," and then help bring them along to wanting other things in general. And I think the model is just an extension of that. More clarity on that and reasons why.

Sam stated that the philosophy of the agency was "pretty close to a perfect match" with the model because the team adapted to the needs of the client instead of the team imposing values or requirements onto the client. Bailey reflected on how the well-being of the client and client rights always came first: "I think that's real positive. Now, every agency says that, but we really work at that, so I think that's a real positive." Terry talked about how the agency was focused on providing "rehabilitative versus habilitative" treatment.

According to 5 of the 6 participants, administrative staff was supportive. Casey stated that the director of the agency was excited when IDDT was introduced to the agency and talked about how the director made numerous changes within the agency in order to adhere to fidelity. For example, the IDDT team members had lower caseloads (i.e., number of clients) and lower productivity expectations (i.e., the expected number of billable hours that the team member is meeting with clients) than the other teams at the agency. According to Casey, caseloads consisted of 15, but no more than 20, clients.

Between the first and second interviews with Pat, the agency had dropped the productivity expectation of the IDDT team members. Pat stated,

> I think it 100% helps that my supervisor is in direct support of what we're doing and believes in it and so he understands that we are going to fall short based on numbers [productivity], but we're not falling short on service and care.

Although team meetings affected productivity, administrative staff was supportive of the need for the team to meet on a weekly basis. Bailey's team meets for two hours one time per week. Bailey stated that at first, this was a struggle and added, "Now it's accepted, because when I went in last time with my administrator and clinical director and said, 'Okay, if we're going to do this, we're going to have to buy into this model.'" Bailey stated that the Executive Director fully supported the model and was open to allowing the meeting to continue.

Sam talked about administration being open to hearing management input and what management is saying. When asked what prompted Sam to join the team, Sam stated, "And I thought very similar [to boss] in terms of management styles. He and I both have the same ideas towards improvement and being the best that you can possibly be and trying to evoke that out of others."

Challenges During Implementation

The participants identified various challenges in their process of transferring research to practice. Although none of the challenges greatly hindered implementation, they did make it more difficult at times (e.g., slowed it down or reversed gains). Some of the challenges that were identified included lack of administrative support, funding,

changing thinking, turnover, state expectations, and fidelity items. At the end of the first interviews, participants were asked to provide comments or recommendations to the creators of the model. The participants' recommendations conclude the section on implementation.

During the second round of interviews, the participants were asked about implementing the model despite challenges. They talked about maintaining focus on fidelity and the model and being realistic about expectations (e.g., assertive outreach may not be possible). Despite challenges, the participants were able to maintain a long-term vision. Terry was able to clearly articulate a long-term vision that withstood any challenges, stating,

> Because the clients need us. I think that's why we all work here: for the clients. . . . I would say that most everybody has the same idea that we work for them [clients] and there's a reason we work here. And it's not for the money or the prestige. It's because we want to give back and we can make a difference. And that's very rewarding, seeing those small little changes.

Pat was also able to articulate a long-term vision:

> It's easy to keep working toward it because I believe it [model] works. Nobody has to sit me down and convince me that group treatment is a good idea for these people and why. Like, I get it. . . . Fidelity—this is going to sound bad—fidelity's not something that I think of on a regular basis in terms of, "Are we going to get a high score on this scale?" I just think of how do I want the program to work and because I fit so well with what they say, it moves forward.

Lack of Administrative Support

At the onset of the study, Chris, Terry, and Pat did not feel that they had the full support of administrative staff. Between the first and second interviews, the problems at Terry's and Pat's agencies were resolved, and administrative staff had made changes that were supportive of the program. However, all three participants were able to clearly articulate how lack of support was detrimental to the program.

Although there was not enough data to formulate a theme, lack of administrative support greatly impacted the team in general and members in particular. The participants talked about organizational changes that administrative staff had made without understanding how the changes impacted implementation of the IDDT Model, and how the lack of support affected morale because team members did not feel valued.

They talked about the need to be a buffer between administration and team members. Terry stated,

> I guess I see it as I have to keep—I don't know if it sounds right—kind of like in a way pumping up my staff, building them up, giving them what they need so they have the willingness to keep the optimism with their clients.

Chris talked about how administrative staff had eliminated incentive programs for the staff and verbalized concern that if administration did not back the model, the program could easily be dismantled, adding

> When you have an administration like that, you go into survival mode. The Team Leader's role becomes a buffer from what's going on administratively so that you can give the clinicians the freedom to continue to do the work on the front line.

> . . . It takes a lot more energy I think to implement when you don't have everybody on board.

Funding

The participants identified funding as a challenge during implementation. They talked about limited funds within the agency and because community mental health agencies are not-for-profit, funding is limited. The participants also talked about the two funding streams in the state of Ohio (i.e., Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services) and how mental health and substance abuse are still perceived as different entities.

Chris stated, "I'm sure they [administration] took a look at cost analysis and things like that. That's always a struggle with agencies to be able to effectively provide, in terms of cost, for this population." Bailey talked about the need for the agency to hire at least one more mental health professional for the team. However, because of limited funds, the agency had been unable to hire additional staff.

The participants talked about the lack of funding related to purchasing educational materials or incentive programs for clients. Pat stated,

> Funding is a huge, huge problem. Even in terms of, you know, like we want to do an incentive program. Just with simple incentives for people [clients] to be able to get haircuts if they're going to work and that sort of thing. And we have such limited wrap-around money that sometimes we can't even find money, you know, that we call for donations. You know, "would you be willing to cut this client's hair for free for us" and that sort of thing.

Bailey talked about the lack of recreational activities available to agency clients:

> I would really like to get back with: it's a nice AA concept where the founders of AA go up to Akron and up to Kent every year and have their week. I would like to have something where our clients could go to for two to three days. . . . I would like to have a two to three day conference with a whole bunch of people. Just like they have at the AA conferences. Have a little bit of music, dance, that's not prohibitive in cost.

Terry talked about a recent donation to the agency and how the clients were able to go bowling. Terry reflected on how it would be helpful to have money that could be used to buy groceries or cigarettes to engage clients: "I would love to have, if we had some type of a grant, like $5,000.00 a year. Some little pot of money that we could do more activities with our clients."

The participants talked about the difficulties inherent in billing for IDDT services. According to Pat,

> It's a program, but you can't bill a dual diagnosis service. . . . If you don't allot money for this specific sort of a service, you have to pull from everything else and that just diffuses the whole thing.

For example, if a clinician were working with a client on alcohol and drug-related services, then billing would need to go through the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). According to the participants, this created difficulty when writing notes because the notes would need to address either mental health or substance use.

The participants talked about the need for certification from both funding streams in order to bill for services. Casey talked about the need for the agency to obtain ODADAS certification in order to bill for treatment groups. Bailey stated,

> The state kind of puts up these barriers. . . . It doesn't matter what door they come in or who is seeing them, as long as I think the client is showing improvement. So, you know, you have to be very careful sometimes with billing. Why? This person should only be using drug and alcohol money because it's drug and alcohol treatment. But they have mental health issues when you're in a drug and alcohol session or vice versa.

Changing Thinking About the Model and Individuals With Co-Occurring Disorders

The participants discussed the difficulties inherent in changing thinking patterns. They talked about the conflict between the IDDT model and the criminal justice system and trying to balance the two. They also talked about the conflict between the traditional philosophy of treatment and the IDDT model and how it impacts both the staff and the community.

The participants talked about having difficulty with the expectations of the criminal justice system. Bailey talked about clients who are referred from the court system: "The court expects one thing and the model has something different in the concept of engagement/pre-engagement stage. And the courts are saying, 'get this guy sober.'" Sam's comments about the philosophical differences between the model and the criminal justice system echoed Bailey's comments. Bailey stated:

> Other systems that we interact with, such as the criminal justice system, aren't familiar with motivational interviewing and stages of change. So, you have a judge who says, "I'm ordering you to the SAMI program." And then we say, "Okay, when you're here, we adapt to your needs. We don't force you to do anything. It's your choice." "Well, then, my choice is I'm not going to be here." "Okay, well, that's okay, but you do realize that there will be consequences to those choices. The judge expects you to be here."

Chris talked about "team politics" and "agency politics" and resistance to change and working within the constructs of the IDDT model:

> You've always got people in any agency that don't understand evidence-based practice. Don't see the value in it. And I think they have their own agenda and they're moving toward that agenda. . . . And you have team members sometimes. You have people that come on the team and think it's going to be one thing and it's not and they don't like it. . . . You have individuals who are kind of stuck in the old addiction, confrontational type of approaches that don't go along with the model.

Sam stated that the psychiatrists and nurse at the agency operate from a medical perspective and are not "motivational interviewing friendly." Sam described the medical staff as rigid:

> The psychiatrists tend to be very traditional, psychiatry based. One is a little more rigid than the other, and they tend to be a little picky about who they will and

won't see and under what conditions. The other psychiatrist can be a little gruff, so that flies in the face of being an empathetic, supportive relationship.

The participants also stated that it was difficult to change thinking within the community. Pat talked about difficulty finding housing for the IDDT clients because the landlords in the community knew the clients and knew of clients' histories. Pat also talked about ancillary services and the difficulty finding other providers who are willing to work with the IDDT clients:

> We can't get them into treatment other places very much to have ancillary services to even get, you know, to go to an after care program or IOP program. They won't take them because they're still using. Or, they won't take them because they're not completely stable on medicine. Or, even if they are stable on medicine, they won't take them because they're schizophrenic. . . . I just think it's hard to break that old way of thinking.

When asked "What have been some things you have learned," Terry strongly stated,

> Mental illness doesn't discriminate. It doesn't care who you are. That the stigmas and stereotypes of the severely mentally ill and drug addicted are just that: stigma. They're not real. It might sound kind of silly, but the folks I work with are the ones that your mom would have said, "Cross the street if you see them coming," and I'm walking towards them with my hands out. And they're wonderful people. They're not mean, they're not violent. They're sick.

Staff Turnover

The participants talked about turnover (i.e., staff leaving the agency) and how it negatively impacted implementation. Chris talked about how the average turnover on the team is between a year and a half to two years. Chris attributed the turnover to "normal career advancement," specifically as it related to case management. According to Chris, the agency was contemplating ways to increase longevity on the team because it is hard on clients when people move around or leave positions.

Terry talked about how the turnover was a "humungous" challenge because the team "was constantly in flux and a lot of chaos" until the past year. Casey also talked about the challenges of turnover: "I think the main challenge is the turnover, not having staff properly trained. . . . Me trying to introduce them to the model and train them at the same time on just our system." Casey reflected on how turnover negatively impacted implementation:

> Sometimes, it's just maybe two people doing it at one time [the model], and you have three people not understanding, so they can't come and assist when needed if they have to help out with the case or that kind of thing. . . . And it's such a high turnover in case managers. So, as soon as they develop a good working team, somebody resigns.

State Expectations

State expectations were also identified as a challenge in implementing the model. The participants talked about the Ohio Department of Mental Health initiatives and requirements that were perceived as inconsistent with the IDDT model.

The participants discussed the Ohio Department of Mental Health Consumer Outcomes initiative, which Sam described as not very IDDT friendly and unnecessarily adds a lot of paperwork. According to Sam and Bailey, the state expectations are broad and objective and do not focus on the individual. Bailey added,

> We're in a world that has gone crazy over outcomes. I can make anything look good, I can make anything look bad. General outcomes are just that. People aren't going around doing nothing in these jobs. That's what they don't understand. People go into these jobs because they want to help. They don't go into it for the money. And, if programs need help, yeah, you develop this and say, "Here are some of the things you should look at." But, when you say general outcomes, okay, so let's say we got 80% of our people in housing. Ah, we've reached our goal, but 78% of those are in drug-infested areas where they shouldn't be in. You run into a situation where they're probably not going to make it. . . . Great, that's a general outcome. What did it do for my specific client? Did it improve his or her life? We worry so much about outcomes that we miss the key thing, is last time I remember, counseling is for individuals. . . . I guess I measure successes by what the clients do. The bottom line is have I in some way in my people given them the tools to improve their lives?

Chris and Sam both discussed state mandates that are passed down to agencies without much forethought. Sam stated,

> It's like the teacher who was in the field for many years and then all of a sudden, they're at the opposite end of the desk and they forget they were students at one

> time. . . . They sometimes lose touch with what's really going on in the world by asking for so many things and so much extra paperwork and so many other things that they want done that they forget the focus has to be on the client.

Chris talked about the leverage that the funding streams have and added,

> Well, I think that when ODMH or ODADAS say, "You need to do this because of the funding pool," the agencies jump. And I don't think that at that level all the time they have a clear idea of what goes on in the front line. So, a lot of times, what ends up happening is you have something that is fairly popular and it's really well known and ODMH is saying, "You need to implement this." But maybe its got some serious problems on the front line. . . . You need to have the supports in place. You need to have the materials in place for people before you throw down mandates like that.

Do Fidelity Items Measure What They Were Intended to Measure?

The participants talked about the disparity between fidelity items and actual practice. Although they appreciated its use as a measure of the implementation process and perceived it as constructive, the participants reflected on whether or not the fidelity scale was a true measure of what occurred in agencies. Chris stated, "It seems to me that there are some measures on the fidelity score that are not truly measuring what they mean to measure of what was intended."

The participants reflected on Organizational Characteristic 3: Penetration (i.e., the number of clients who are eligible for treatment versus the number of clients actually

served by the program; see Appendix B), and whether or not it was a true measure of what was originally intended. Pat stated,

> We have umpteen thousand clients who come here and the model itself is specifically for quadrant four. And you can do it to anybody but if you look at the model and what they look at as just the quadrant four of the model. . . . We have all sorts of people who meet a dual diagnosis criteria but wouldn't necessarily meet the eligibility for the program. And so it's one of those things too where it constantly looks like a low number and failure.

Sam talked about the number of staff at the agency on the IDDT Team and how it was difficult to serve all the clients in need of IDDT services. Chris also talked about difficulty adhering to this fidelity item: "It just seems to me that when every agency is scoring low on a fidelity score, there's something wrong with the score and we can't be that bad at it across the board."

The participants reflected on how productivity standards (i.e., the expected number of billable hours that the employee is meeting with clients) set an unfair standard and negatively impacted implementation. Pat stated, "The standards of productivity aren't set up to be supportive of doing an evidence-based practice." For example, the provision of assertive outreach (Treatment Characteristic 5) requires staff to go into the community and provide services in the client's natural environment. According to Bailey, the time that clinicians spend driving throughout the county is problematic: "If you look at our county, our county is very wide as far as land. . . . Our case managers are just continually traveling all over."

According to the participants, the difficulty with providing outreach is that many times, staff needs to actually find the client or when they do find the client, the client does not want services. Chris added, "They're tough to find a lot of times. . . . It's hard to get access to the clients and help them get to the point that they're willing to do the work." The time spent in these activities cannot be billed, and the clinician takes the chance that disciplinary action may be taken if productivity does not meet expectations. Pat stated,

> When you have a counselor who is at 50% productivity and you want them to do assertive outreach which means driving around in their car to find them, and none of that counts, it's kind of like you're saying, "Do that, but I'm still gonna spank you when you get back." And it's just not fair.

Comments or Recommendations to the Creators of the Model

During the first set of interviews, participants were asked about comments or recommendations that they would offer to the creators of the model. The participants described resources that they felt would be helpful in learning about and implementing the model. Sam stated,

> It's been tough in that a lot of the resources or things that I think would have been helpful early on just weren't available at the time. . . . More readily available resources. What they have now is good, but it would be nice to have more. . . . Having the video conferences and regional meetings are good as long as they are focused on something new. Sounds like the same old stuff rehashed. After the last training, staff stated, "We already knew this." It's so general. There aren't

concrete implications. The practical is not addressed. They tell you what to do but not how to do it.

Casey and Terry stated that they would ask for more specific information. Terry added, "More specifics on documentation and stage-wise treatment. Just to have a resource of some kind of documentation manual for stages of treatment." Casey stated that when trainers come to work with staff and train staff on the model, they need to provide "training around different interventions that they have seen work on clients when it gets to the persuasion stage."

Bailey talked about being aware of the criticisms of the model and contributed the following recommendation:

> So, I think what they also should do is, when they [the SAMI CCOE] go in, possibly say to the people, "Here's what we think the model is, and this is what we want to do. Now, I want you to understand that there's critics on the other side that don't think our model works very well." And I think that they should be open and maybe tell people that.

Extraneous Data

Three main themes emerged from the data. However, during the interviews, the participants provided additional information that is described in this section and includes lack of consistency in the fidelity review process, working with clients who are not motivated, lack of administrative skills, and successes within the respective programs. Even though themes did not emerge from the following data, the data is noteworthy.

Terry and Sam reflected on the fidelity review process. Sam verbalized a sense of frustration because of the gap in time between the physical fidelity review and receipt of the fidelity report, which was approximately five months. Sam added, "So, as I'm learning the model, and learning the program, and learning the agency, and not having that frame of reference basis, that was I think some of my biggest source of frustration." Terry reflected on the perceived lack of consistency between fidelity reviews and stated,

> I would like to see when you have a fidelity review, to have a – you know how they come up with that wonderful action plan for you to do? But then next year when we have another one, there's no reference to it . . . and I've mentioned it to them. I go, "That doesn't make any sense to me. You've given me these recommendations and I'm actually coming up with an action plan, doing many of those things but during our fidelity review, we're not specifically going over, 'Now, I did this, I did this.'" To show, to have that concrete—because it could be four new reviewers.

Bailey talked about the need to modify the model according to agency limitations, adding, "The model just can't always work in the way it was designed to do with different places." For example, funding streams made it difficult for the agency to maintain the low client-to-clinician ratio called for in the model. Bailey stated,

> Of course it works [IDDT], but again we have to get into the situation of we can't do the model as the model expects us to do. We can't have caseloads of 25 people per staff because we do it all.

Chris and Bailey reflected on working with clients who are not motivated. Bailey talked about the potential of working within a reward system:

> There are certain clients that I've worked with for 10-15 years that I know are never going to pass pre-engagement or engagement. Because they want to continue to use or they are continually not motivated to do things. . . . What we need to do basically, if we could work things on a reward system, I think it would work out very well. I think that part of the rewards are, you know, you start to get sober, we can find you a job, which will help you keep your SSI, and still continue to work a little bit and make extra money. We can basically try to help you find a place to live. Even though you might not qualify for some of our programming, which most of them do. Find you an apartment and a place that is livable and not using places . . .

Chris talked about difficulties in accessing and engaging clients and the impact on clinicians, stating,

> I think it's frustrating for the clinicians a lot of times. They're energized about this program. They feel that they have something that can really help people and it's frustrating when people aren't ready to take that, utilize that. They're not at that point in their recovery. And they can see the potential in the people they're working with but they're just not ready to change yet. So, it's frustrating. It kind of brings down morale a little bit. It can contribute to burn-out, depending on how seriously they take that and how accepting the clinician is to the client's unwillingness to change.

Like the other participants, Chris had discussed the difficulty of changing thinking. However, Chris was the only participant who talked about clients who have difficulty changing their own thinking about the way treatment is provided adding,

> Clients get used to how things have always been, and they expect that things are going to be the way they were 5 to 10 years ago. And if we're expecting them to be independent and do things on their own and grow and move forward rather than doing everything for them, then they have a lot more resistance in changing as well. . . . Older clients not wanting to change and doing things differently and, "Why are you expecting me to do this on my own now and my last five case managers did it for me"?

When asked "What have been some things you have learned," Chris reflected on how clinicians were placed into administrative roles without administrative and business knowledge. This lack of knowledge made it difficult for administrative staff to work together. Chris stated,

> I've learned that I don't have as much business knowledge as I would like to. You know, on a common sense standpoint, I can engage in discussions about business practice, but I can see when you've got a situation where not everybody in the agency is on the same page and you've got business people and you've got clinicians and you've got combinations of both. I can really see the benefit of having more training on the business end and be able to say, "Yeah, I can see it from both sides." Or, "What you're trying to sell me in terms of this is best for the agency from a business standpoint is a bunch of bull." And so, having more

> knowledge about business practices. That's something I would like to grow more in. But I have learned that's important in clinicians too. A lot of us start out as clinicians and we're put in these administrative roles and we're expected to know business and do that side of it, and I think that's kind of lacking. It is lacking in the administration in these types of agencies. And I think it would be good to have more knowledge in that area.

During the first round of interviews, the participants were asked to reflect on where they were currently succeeding in their programs. The participants talked about being more focused on outcomes and documentation, offering various groups to the clients, and reduced hospitalization rates. Pat, Terry, Casey, and Sam all felt that their respective teams were able to effectively engage clients in services. During the second interview, Sam reflected on the team's competence in motivational interviewing, adding,

> I think some of the strengths of our program is that we really do engage the clients well once they are here and we offer a wide variety of groups for them that are stage-based. I really think that we implement the philosophies of motivational interviewing in terms of meeting the client where they are, in terms of adapting to the client needs and building that empathetic, supportive relationship. And because we don't require abstinence in relation to how other programs locally operate, people find it such a refreshing change that they enjoy coming here. So, I really think that's some of our strengths.

Bailey's measure of programmatic success was focused on client care:

> I guess I measure successes by what the clients do. The bottom line is have I in some way in my people given them the tools to improve their lives? Have they found a better place to live? Are they living a little better now? Have the life changes made improvements in their life? I measure things in a very small way, I guess. "Boy, so and so is eating better, you're gaining weight, you know, you didn't look too good a couple months ago, but now your starting to gain weight." I guess that's the way I look at things and I think the IDDT model really serves that purpose. It's a step to try to get them back slowly into the changes of life.

Summary

Chapter 3 focused on data collected from interviews with 6 IDDT Team Leaders. Three themes emerged from the data: learning to be an IDDT Team Leader, learning about and embracing the IDDT model, and implementing the IDDT model. These themes were discussed in Chapter 3. Extraneous data from the interviews were also presented.

What was most salient in the data was how implementation was a multi-dimensional process. As the participants moved through these processes, they developed a leadership style that was consistent with both the IDDT model and the literature on leadership excellence. The participants were passionate about the model and visionary, maintaining a clear vision of the direction of implementation which was focused on providing good client care. They *walked the talk* (Kouzes & Posner, 2002) and became the champion of the model within their respective agencies. In Chapter 4, a summary of findings from the data is presented, along with interpretation of the data and a comparison of data with the existing literature.

CHAPTER IV

DISCUSSION

The purpose of the current study was to address the lack of research on implementation of an evidence-based practice by exploring how 6 IDDT Team Leaders implemented the IDDT model. The primary research question that guided the current study was: How do 6 IDDT Team Leaders in Ohio describe their experiences of implementing the IDDT model? In Chapter 3, the three main themes that emerged in the data were described. These themes included: (a) learning to be an IDDT Team Leader, (b) learning about and embracing the IDDT model, and (c) implementing the IDDT model.

In Chapter 4, findings from the current study are analyzed and described. Chapter 4 is organized into eight sections:

1. The first section presents the main findings.
2. The second section addresses additional findings in the current study.
3. The third section addresses the implications for the Ohio SAMI CCOE and the counseling field, including counselor education and the practice of counseling.
4. The fourth section addresses the limitations of the current study.
5. The fifth section addresses the delimitations for the current study.
6. The sixth section presents recommendations for theory and research.
7. The experience of the researcher is presented in the seventh section.
8. Finally, the eighth section is a summary of Chapter 4.

Main Findings

Results of the current study suggest the possibility of a model of implementation as a multi-dimensional process. According to the model, three processes occur simultaneously during the implementation process and include: (a) learning to be an IDDT Team Leader, (b) learning about and embracing the IDDT model, and (c) implementing the IDDT model. For the participants who did not have exposure to the IDDT model prior to taking on the Team Leader role, they needed to learn about each of these processes simultaneously. Participants with prior exposure to the model had experienced the process of learning about and embracing the IDDT model before taking on the role of IDDT Team Leader. However, after taking on the role of IDDT Team Leader, they needed to simultaneously navigate the processes of learning to be an IDDT Team Leader and implementing the IDDT model.

According to the data, although each of the participants began their journey from different treatment perspectives (e.g., mental health only, substance abuse only) and roles (e.g., supervisor, IDDT team member, counselor) prior to taking on the role of IDDT Team Leader, they moved through the processes in a similar manner. The data demonstrated that as they navigated these processes, the participants developed and refined a long-term vision of implementation that was focused on providing good client care. This clearly defined vision was what pulled the Team Leaders forward (Kouzes & Posner, 2002) and inspired the team to share in the vision (Glaser, 2006). Findings indicated that as the Team Leaders moved through these processes, they developed a leadership style that was both compatible with the model (e.g., stages of change,

multidisciplinary team) and congruent with the literature on leadership excellence (e.g., integrity, character; Zauderer, 1992, 2005). This finding is woven throughout the data. In this section, findings from the current study are summarized and linked to existing literature.

Learning to be an IDDT Team Leader

Participants noted that the process of learning to be an IDDT Team Leader was challenging yet rewarding. They verbalized the need to learn how to be a Team Leader, work within the framework of a team, and balance various responsibilities. The data support the finding that the participants were able to maintain focus on the long-term vision of providing good client care throughout the process. This finding should be explored in future research.

The participants experienced numerous thoughts and feelings that were at times dichotomous (e.g., "exciting," "scary") and overwhelming. Although the participants struggled when taking on the role of Team Leader, they were able to maintain self-awareness and verbalized an understanding of the unrealistic expectations that they had placed on themselves after taking on this new role. They learned to regulate their feelings and constrain impulses to overreact (Zauderer, 2005) and approached the task of leadership with an attitude of humility and servitude, recognizing the importance of the team. According to Zauderer, "Humble leaders recognize that enlightened solutions to complex problems evolve when leaders listen and engage in active inquiry with different stakeholders" (p. 48). Although the participants were charged with leading the team, they viewed themselves as a member of their respective teams. They focused on service to

others and did not inflate themselves (Zauderer). According to the perception of the participants, they actively pursued input from team members and maintained an open stance that they were willing to learn from them.

Implementation of many evidence-based practices requires teamwork (Corrigan et al., 2001). According to Corrigan et al., a lack of teamwork contributes to numerous negative consequences, including burnout and inability to develop a cohesive plan. The data support the finding that the participants recognized the need to learn to work within a team concept and foster mutual reliance within the team (Kouzes & Posner, 2002) in order to successfully implement the model. As a result, they realized that successful implementation was dependent on the team and not one individual and were able to *aim at the mean* (e.g., "I got out of the fact that it was about me;" Zauderer, 2005). According to the perception of the participants, they dispersed power among the team members and did not take an authoritarian stance.

Corrigan et al. (2001) identified two types of leadership that are effective for service teams: transformational and transactional. Findings indicated that the participants engaged in transformational leadership, evidenced by their efforts to motivate and inspire team members. This type of leader is thought to increase intrinsic motivation, create a vision, and inspire team members to go beyond expectations of the job (Aarons, 2006). The participants appeared to foster civility among team members (Zauderer, 2005) and find balance between being in charge of the team and being a part of the team in order to create equality among the team members. They fostered a shared vision (Sankar, 2003)

by eliciting intrinsic belief in the long-term vision of providing good client care among team members.

According to Zauderer (2005), "A responsible life focuses on service to others and on purposes that transcend self-interest" (p. 46). The participants perceived themselves as strongly dedicated to both the clients and team and respected team members as individuals. Despite numerous responsibilities, the participants verbalized the need to be flexible in order to not only make themselves available to team members but also maintain focus on client care. According to the experience of participants, caring about the team members was an integral component of implementation. Zauderer stated that "caring supervisors coach their staff for career enhancement and help them perform better on the job" (p. 49). The participants described themselves as approachable and open to team members and verbalized the need to not only develop relationships with and among team members but also empower team members and foster shared accountability. According to Kouzes and Posner (2002), the leader needs to trust that the team members are capable of decision making and allow them to take ownership of, and be accountable for, implementation. In addition, effective leaders establish an open environment where team members can freely talk and involve team members in decision making (Glaser, 2006). Findings indicated that the participants held the expectation that the team members were capable of making their own decisions and actively involved team members in decisions that would impact implementation. In addition, they fostered an environment of collaboration and accountability (e.g., "It's not your responsibility solely or mine. If we go down, we all go down") where the team could work together to provide

effective services to clients (Norman & Peck, 1999). According to the experience of participants, they relied on the team members' knowledge and valued the input of the team (Pfeffer, 1999). The participants verbalized the expectation that team members needed to work together and resolve interpersonal problems without intervention.

Learning About and Embracing the IDDT Model

Each of the participants came from a different treatment perspective prior to taking on the role of Team Leader. However, findings indicated that regardless of prior treatment perspective, the participants quickly embraced the philosophy of the model. According to the data, the participants integrated aspects of the model into their leadership style and embodied the philosophy of the model in interactions with team members. The data demonstrated that throughout the process of learning about and embracing the IDDT model, the participants continued to develop their leadership styles. These findings should be explored in future research.

The match between the IDDT model and supervisor could possibly ease the implementation process (Boyle & Wieder, 2007). The data support the finding that the participants quickly embraced the philosophy of the IDDT model. They verbalized an appreciation of and belief in the model and were able to recognize the congruence between the basic tenants of the model and their personal philosophies (e.g., "I just think it's who I am to be honest with you"). Results of the current study suggest that as the participants learned about and embraced the IDDT model, their vision of providing good client care was strengthened. According to the experience of participants, the model created structure and direction for treatment and guided them during implementation.

The data support the finding that the core value of the IDDT model, shared decision making (Mueser, Noordsy, et al., 2003), was consistent with the participants' view of the provision of treatment (e.g., "at the other person's pace, respecting the person"). The participants verbalized that they did not hold certain expectations of clients and were willing to work with clients regardless of whether the client chose to use substances (e.g., "And hopefully one day when the client is ready, they get sober."). According to the perception of participants, they maintained optimism that the client would some day maintain abstinence but were realistic and understood that change was a process that could take years.

Findings indicated that the participants integrated aspects of the model into their leadership style. When asked to describe their leadership style, the participants used descriptors that resonated with the model (e.g., motivator, stage minded, flexible, strength minded). The data support the finding that the participants incorporated motivational interviewing into their interactions with team members (e.g., "What I try to do is I use a lot of motivational interviewing, a lot of open-ended questions and I use a lot of metaphors with them when I supervise."). The participants verbalized the need to motivate the team so that they did not become discouraged in their work with clients and would continue to strive to provide good service.

According to the data, the participants used stages of change not only with clients, but also in interactions with team members and administration. The participants had verbalized a sense of frustration during the first interviews, and when this frustration was explored during the second interviews, the participants recognized that the frustration was

a part of their own change process. According to the experience of participants, they were not applying a stage of change concept in their daily interaction with staff and held expectations that were unreasonable (e.g., "I'm ready to implement. I'm in action, and they're in precontemplation . . . So, just, sometimes, I think I'm just ahead of them. I'm just ready to start doing some things and they're not."). If a leader makes changes and team members are not ready for the change, the initiative is more likely to fail because of staff resistance (Prochaska et al., 2001). The participants verbalized the need to stage self, clients, administration, and team members and hold reasonable expectations within a respective stage of change (e.g.," I've learned how to really try to treat each of my staff differently just like my clients. Each are in different places, have different needs."). According to Prochaska et al., the likelihood of success increases through continuous monitoring of stages and working within the respective stages. Findings indicated that the participants were intentional in understanding team members and their respective stage of change. The participants verbalized the need to look for strengths in each team member and use those strengths to help team members grow as both individuals and as a team. They perceived themselves as supportive and committed to developing the full potential of each team member.

The data demonstrated that as the Team Leaders moved through the process of learning about and embracing the IDDT model, they continued to develop a leadership style. According to Thomas (2005), the leader needs to share their vision with others and live it every day. Through their actions and attitudes (i.e., practicing what they preached), the participants led by example (Klann, 2003). They verbalized continued concern for the

welfare of team members and fostered civility by continuously motivating their staff to help them perform better on the job (Zauderer, 2005). Findings indicated that the participants maintained humility by recognizing that they were not in control of clients' choices and were willing to meet a client within his or her respective stage of change. Humility was also evident in their expectations of staff. According to the perception of participants, they did not demand that team members comply with standards; instead, the participants took the time to understand team member's stage of change and allowed the team members to choose how they would provide treatment.

Implementing the IDDT Model

The participants noted that they were exposed to various facilitators and challenges during the implementation process. Findings indicated that the facilitators were either imposed by the participants (i.e., creating structure, building a strong, cohesive team) or external factors (i.e., the Ohio SAMI CCOE, administrative support). Findings also indicated that various challenges were present (e.g., lack of support, funding, changing thinking); however, the participants did not view the challenges as barriers. According to the experience of the participants, the challenges appeared to slow down implementation at times; however, they were able to maintain focus on the long-term goal of providing good client care and continued to implement the model despite challenges. The data demonstrated that during the process of implementation, the participants continued to develop their leadership style. These findings should be explored in future research.

According to the data, after taking on the role of Team Leader, the participants made changes to the program in order to build a solid structure. The participants established continuous supervision and coaching within team meetings in order to reinforce trainings and maintain awareness of the model and its components (Fixsen et al., 2005). In their study, Wieder et al. (2007) found that "the quality of IDDT supervision and the team leader's enthusiasm emerged as pivotal to the potential of a new team" (p. 152). Results of the current study suggest that the participants continuously educated the team about the model in order to develop a sense of mastery and competence in the model (Nelson et al., 2006). Cohesion and collaboration among team members, along with competence in the model, is strengthened through regular supervision and team meetings (W.C. Torrey et al., 2001). Furthermore, clinicians are more willing to adopt a practice if the practice is reinforced over time (Nelson et al., 2006; W.C. Torrey et al., 2001). The participants verbalized the need for team members to understand expectations of the agency, model, and teamwork. According to the data, the participants worked to instill a sense of shared responsibility among team members and expected the team members to work together and attend team meetings. The participants not only established set times to meet as a team but also established a set protocol within the team meetings. Although the participants verbalized that it was difficult to establish structure at first, they stated that team members were seeing the benefit of the structure.

The data demonstrated that a strong, cohesive team was important during the implementation process. Wieder et al. (2007) found that having the right people on the

team positively impacted implementation. The participants verbalized the importance of having the right team members in order to implement the model and recognized the negative impact of individuals who held expectations that contradicted the model's philosophy (e.g., "We had a few members who are gone now that were just too negative. That pessimism was like a venom that just kind of oozed everywhere."). Provider attitudes about openness to change, the IDDT model, and individuals with co-occurring disorders, along with willingness to work with a challenging population, can negatively or positively impact implementation (Wieder et al., 2007). The data support the finding that the participants had learned to identify individuals whom they considered good for the team and actively looked for team members with certain characteristics. The participants noted that first and foremost, team members not only needed to be able to work as a team but also needed to be client focused. Other characteristics that the participants looked for in prospective team members were caring, compassion, humility, optimism, hope, and flexibility.

In their study, William Torrey et al. (2001) found that consultation opportunities (e.g., experts that would be available for consultation with providers) and web-based resources (e.g., a website that would link providers with current research studies) would increase the likelihood of successfully implementing an evidence-based practice. Wieder and Kruszynski (2007) also found that expert ongoing supervision and technical assistance reinforced IDDT clinician training and was seen as necessary during implementation. According to the experience of the participants, the Ohio SAMI CCOE was perceived as a facilitator or change agent (Rogers, 1995) during implementation. The

participants stated that the conferences and regional meetings were not only helpful in the learning process, but also helpful in connecting them with other IDDT providers. Through the use of these forums, interpersonal channels (Rogers) were created. According to the experience of participants, these forums provided support, strategies, and advice during the implementation process (SAMHSA, 2003). The participants perceived SAMI CCOE staff as both a good resource and helpful throughout the implementation process. The participants verbalized an appreciation of having an objective third party available to offer education, consultation, and a listening ear.

In order to sustain an evidence-based practice, the philosophy of an evidence-based practice needs to be incorporated into daily practice (Drake et al., 2003). Furthermore, program longevity is compromised if organizational characteristics are not in place (Mueser, Noordsy, et al., 2003). Findings of the current study indicated that the philosophy of the IDDT model was compatible with the philosophy of the agency, which eased the process of implementation. According to the experience of all participants, both the agency and model philosophies focused on client choice, and 5 of the 6 participants verbalized an appreciation of the support that they had from administrative staff. According to Panzano et al. (2002), support from top management is a key to successful implementation. The data demonstrated that supportive administrative staff was more willing to adhere to fidelity to the model and make necessary changes (e.g., lowering both productivity expectations and caseloads, supporting team meetings) in order to implement the model.

The participants were asked to talk about challenges that they encountered during the implementation process. According to Thomas (2005), the leader who has a vision is able to be persistent despite setbacks or problems. The data support the finding that the participants continued to implement the model despite challenges. The participants verbalized that they were able to maintain focus on good client care and held realistic expectations about implementation. The challenges that the participants identified included lack of administrative support, funding, changing thinking about the model and individuals with co-occurring disorders, staff turnover, state expectations, and whether fidelity items truly measure what they were intended to measure. The participants also offered comments or recommendations to the creators of the model.

During the first interviews, 3 participants verbalized that they did not feel they had the support of administration. Between the first and second interviews, the climate changed at two of the three agencies and according to these participants, administration became supportive of the respective programs. Although the climates changed, the negative impact of lack of administrative support on implementation is noteworthy. According to Fixsen et al. (2005), a lack of attitudinal and structural changes within the organization results in the failure to sustain a program. The data support the finding that lack of administrative support negatively impacted implementation. Participants noted how changes made to the program without the team's input negatively impacted staff morale. They also noted how they felt the need to buffer staff from administration that did not support implementation of the model in order for staff to maintain optimism about implementation.

Funding in relation to internal (i.e., agency) and external (i.e., state) resources were identified as another challenge during implementation. According to the data, limited agency funding impacted staffing and hindered incentive programs that the participants felt would assist the clients in their recovery (e.g., "Just with simple incentives for people [clients] to be able to get haircuts if they're going to work and that sort of thing."). However, findings indicated that the participants were resourceful and were able to obtain money and donations from different sources.

Two separate funding streams (i.e., mental health and substance abuse) present challenges that affect implementation (Azrin & Goldman, 2005; New Freedom Commission, 2005; SAMHSA, 2003). Results of the current study support the finding that the two funding streams in the state of Ohio created problems with billing for services. The data demonstrated that some of the agencies needed to obtain certification from both the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services in order to receive reimbursement for services. According to the experience of participants, the two funding streams made it difficult to write case notes because clinicians needed to address either mental health or substance use in a note, depending on the funding stream.

The participants talked about the difficulties inherent in changing thinking patterns. The core value of the IDDT model, shared decision making, is based on the premise that clients have the ability to pursue and attain their own goals, function within society, and achieve recovery from both disorders (Drake, Morse, et al., 2004; Corrigan et al., 2001; New Freedom Commission, 2005). Results of the current study support the

finding that thinking in relation to the provision of traditional treatment versus the IDDT model presented a challenge during implementation. Participants noted how the philosophy of agencies and systems in the community (e.g., criminal justice system) conflicted with the IDDT philosophy and made it difficult to work together. Participants also noted that the perception of individuals with co-occurring disorders (i.e., stigma) within the community (e.g., landlords) was persistent. According to the experience of participants, even within an agency, various individuals (e.g., nurses, psychiatrists) adhered to older models of treatment, which made it challenging to work together as a team (Norman & Peck, 1999).

According to Wieder et al. (2007), training costs associated with staff turnover are substantial. Turnover can be attributed to staff leaving the agency, termination, or transfer (Wieder et al.), and makes training and continuity of care difficult (Biegel et al., 2003; Boyle & Kroon, 2006). Results of the current study support the finding that staff turnover had a negative impact on implementation, making it difficult to develop team cohesiveness. According to the experience of participants, the constant flux of new staff that needed to be trained not only about the model but also about the agency made it difficult to maintain consistency in care (e.g., "It's just maybe two people doing it [the model] at one time, and you have three people not understanding, so they can't come and assist when needed if they have to help out with the case.").

The data demonstrated that another challenge during implementation was state expectations. Participants verbalized the discordance between the outcomes identified in an evidence-based practice and outcomes identified by the state of Ohio (e.g., "We worry

so much about outcomes that we miss the key thing, is last time I remember, counseling is for individuals."). According to the experience of participants, the Ohio Department of Mental Health Consumer Outcomes initiative was focused on broad, overall outcomes that were not relevant to individual clients and created unnecessary paperwork. Findings indicated that state mandates that are passed down to agencies are often unrelated to actual practice (e.g., "They [the state] sometimes lose touch with what's really going on in the world by asking for so many things and so much extra paperwork and so many other things that they want done that they forget the focus has to be on the client.").

According to McHugo et al. (1999), if a treatment program receives a low fidelity rating, client outcomes cannot be attributed to the original model. However, results of the current study indicated that there is a disparity between fidelity items and actual practice. According to the experience of participants, two fidelity items (i.e., Penetration and Assertive Outreach) set unfair standards that are not practical. The participants verbalized that this disparity presented a challenge during implementation (e.g., "When you have a counselor who is at 50% productivity and you want them to do assertive outreach which means driving around in their car to find them, and none of that counts, it's kind of like you're saying, 'Do that, but I'm still gonna spank you when you get back.' And it's just not fair.") and questioned whether these items truly represented actual practice (e.g., "It seems to me that there are some measures on the fidelity score that are not truly measuring what they mean to measure of what was intended.").

The participants were asked to offer comments or recommendations to the creators of the model. According to the experience of participants, they felt that it would

have been helpful to have more readily available resources during the implementation process (e.g., "Just to have a resource of some kind of documentation manual for stages of treatment."). The participants verbalized an appreciation of the existing materials but felt that they needed to be updated on a regular basis (e.g., "Sounds like the same old stuff rehashed.").

According to the data, although various criticisms about the use of evidence-based practice are present, providers are not informed about them. One recommendation that was offered was to inform providers about the criticisms in order to allow prospective providers to make an informed decision about whether or not to implement the IDDT model (e.g., "So, I think what they also should do is, when they [the SAMI CCOE] go in, possibly say to the people, 'Here's what we think the model is, and this is what we want to do. Now, I want you to understand that there's critics on the other side that don't think our model works very well.' And I think that they should be open and maybe tell people that.").

The data demonstrated that throughout the process of implementation, the participants continued to develop their leadership style. According to Aarons (2006), leadership is a vital component in shaping the attitudes of staff and organizations and in the adoption of innovations. According to the data, the participants fostered a sense of shared responsibility and recognized their own accountability in the implementation process. Findings indicated that the participants had courage and fierce resolve (Zauderer, 2005) and were able to make changes (e.g., creating structure, finding the right team

members) in order to create a strong, cohesive team that shared the long-term vision of providing good client care.

Additional Findings

Each of the participants contributed to the main findings in this study. However, additional findings are noteworthy and are described in this section. Additional findings included a lack of consistency in the fidelity review process, modifying the model, working with clients who are not motivated, changing client's thinking about the model, and lack of administrative skills. Each of these findings is discussed below.

Lack of Consistency in the Fidelity Review Process

One way to ensure successful implementation is to provide consistent feedback to practitioners about the process of implementation and the outcomes derived from this process (Fixsen et al., 2005; SAMHSA, 2003). According to the experience of two participants, there was a lack of consistency in the fidelity review process that included not only the time span between the fidelity review and receipt of the fidelity report but also inconsistency between fidelity reviews.

One participant verbalized frustration about the gap in time between the actual fidelity review and receipt of the fidelity report (approximately five months), stating that it was difficult to make changes to the program without a point of reference. If fidelity reviews occur on an annual basis and a program does not receive feedback on a timely basis, it may be difficult to make changes that can be accurately evaluated during the next fidelity review. For example, if an organization does not have the means to identify clients who are eligible for IDDT services (Organizational Factor 2), then the

organization would need to develop a strategy or system to identify these clients. Creating a system may take months to initiate and formalize and if the organization does not receive timely feedback from a fidelity review, it may be in the midst of change during the next fidelity review. As a result, the organization would receive a lower rating on the fidelity item. In sum, timely feedback would give the organization the ability to establish a long-term framework for modifying the program and systems. These modifications could be evaluated during the next fidelity review, and the reviewers would be able to provide recommendations based on established changes within the organization.

Another participant discussed the lack of consistency between fidelity reviews. According to this participant, changes to the program were made based on the fidelity review and an action plan was created (i.e., changes that needed to be made). However, when the next fidelity review occurred, the reviewers did not ask to look at the action plan and many times were not aware of recommendations that were made during the previous fidelity review. If the fidelity reviewers examine the organization's action plan, they may be able to determine whether the changes that were made will assist the organization in adherence to fidelity. For example, if an organization adds groups to the array of services in order to increase fidelity to Group Dual Disorder Treatment (Treatment Characteristic 8) as part of the action plan, the fidelity reviewers would be able to intentionally review curriculum and materials for the groups to ensure that they are aligned with the model. If the changes are incorrect (e.g., using relapse prevention materials in a persuasion group), the reviewers would be able to provide feedback based

on the existing change and offer recommendations for additional changes that would increase adherence to fidelity. This would allow the organization to build on change instead of consistently making new changes to the program.

Modifying the Model

An evidence-based practice may not fit with what clinicians are already doing in their daily work or may be too costly to implement (McGovern et al., 2004). Biegel et al. (2003) acknowledged that slight deviations (or re-invention) from the original model would need to take place at agencies throughout the state of Ohio. However, core components of a model must be retained in order to achieve fidelity (Fixsen et al., 2005) and if a program is modified, the success of the program may be jeopardized (McHugo et al., 1999; Panzano et al., 2002).

According to the experience of one participant, certain limitations within the agency made it difficult to adhere to fidelity (e.g., "The model just can't always work in the way it was designed to do with different places."). This participant discussed how limitations negatively impacted certain items on the fidelity scale, resulting in low scores on that item and ultimately impacting outcomes. If an agency is able to accommodate the needs of IDDT clients and adhere to the core components of the model, then rigid adherence to fidelity items may not be mandatory. For example, due to the comprehensive nature of the IDDT model and the intense time requirements (e.g., outreach), it may not be feasible for staff who work with IDDT clients to carry large caseloads. However, if agency staff is able to meet client needs even with a large caseload and can provide evidence that needs are met, then it may not be necessary to

adhere to a specified staff to client ratio. On the other hand, if the agency is unable to accommodate the needs of clients, then it may be appropriate to reevaluate the organizational commitment to implementation of the model.

Working With Clients who are not Motivated

One participant reflected on how changing client's thinking in regard to treatment and working within the model can be difficult. Whereas the IDDT model focuses on client choice and independence, traditional treatment did not foster independence. According to the experience of one participant, some clients, specifically older clients, were more dependent on the agency to meet their needs and were resistant to the philosophy of the model.

Two participants noted that despite the efforts of the team and working within the model, there are clients who are not motivated to change and may not make any progress. As a result, the lack of progress and motivation could potentially contribute to clinician frustration and burn-out. Four fidelity items may potentially be impacted by clients who are not motivated: (a) eligibility/client identification (Organizational Factor 2), (b) penetration (Organization Factor 3), (c) client choice (Organization Factor 12), and (d) outreach (Treatment Characteristic 5). If a client chooses to continue using substances after a number of years in treatment (e.g., "There are certain clients that I've worked with for 10-15 years that I know are never going to pass pre-engagement or engagement."), does not show a desire to cut back or stop using, and does not want IDDT services, an agency may need to reconsider whether to continue offering IDDT services and outreach to the client. However, once a client is identified as eligible for IDDT services, the

penetration ratio is impacted. If the number of clients eligible for but not interested in IDDT services is large enough, an agency may have difficulty adhering to fidelity to penetration.

One concern about evidence-based practices is rigid adherence to a model and specific techniques rather than tailoring treatment to individuals' problems and needs (Anthony et al., 2003; Dixon, 2004; Frese et al., 2001; Persons & Silberschatz, 1998; Tanenbaum, 2003). In keeping with client choice and preference, agencies may need to provide services unrelated to IDDT to those clients who do not wish to be involved in the IDDT program. Although the IDDT model has proven effective with numerous clients, it will not work with every client. Therefore, IDDT providers may need to establish criteria for disengaging from clients who are not interested in IDDT services and finding alternative treatment modes.

Lack of Administrative Skills

Within their study, Wieder et al. (2007) found that lack of administrative skills on the part of the IDDT Team Leader, along with lack of support from administration (i.e., managerial support), negatively impacted not only implementation but also employability (e.g., one Team Leader in their study was fired due to inability to grasp skills). One participant noted that clinicians are placed into administrative roles with a lack of business and administrative knowledge. This participant verbalized that the lack of knowledge makes it difficult for clinicians to effectively communicate with administrative staff and creates a narrow focus in which clinicians are unable to identify how administrative expectations (e.g., productivity) impact the agency in the long run.

Regarding this finding, it may be beneficial for agencies to offer education to individuals placed into administrative roles. Such education could include an overview of finance, administrative expectations, and basic managerial skills with an overall goal of assisting individuals in feeling competent as managers.

Implications for the Ohio SAMI CCOE

Findings in the current study present implications for the Ohio SAMI CCOE. These implications include the provision of training material that expands the knowledge base, informing providers about criticisms of the model, providing consistent feedback from fidelity reviews, and modifications to the IDDT model.

Results of the current study indicate that training provided by the SAMI CCOE is perceived as redundant at times and does not advance practitioner knowledge. When asked to give recommendations, the participants stated that they would appreciate materials that would provide information on application of the model (e.g., "More specifics on documentation and stage-wise treatment") and training that focused on interventions that have been used in practice. Because of staff turnover and the constant flux of new IDDT providers, it may be difficult to provide training to adequately address individual needs. Instead of providing broad training to agency staff, it may be more beneficial to separate providers and offer training that is tailored to advancing providers' current knowledge base.

According to one participant, providers are not informed about the criticisms of the IDDT model and should be informed about criticisms prior to implementation efforts. By informing providers about criticisms (e.g., proponents of the recovery model, loss of

individuality within evidence-based practice), providers would be able to make an informed decision about whether or not to implement the IDDT model. However, if providers are informed about criticisms, they would also need to be informed of arguments in favor of the use of evidence-based practice (e.g., W. R. Miller et al., 2005). Providers could use both arguments to contemplate the adoption decision.

Within the current study, two participants discussed the lack of consistency in the fidelity process that included a gap in time between the fidelity review and receipt of the fidelity report and lack of review of action plans created between fidelity reviews. During the time period for data collection in the current study, the Ohio SAMI CCOE had posted a job opening for a Manager of Program Evaluation Services. The creation of this position was intended to address the gap in time between the fidelity review and receipt of the fidelity report. To address the lack of review of action plans, it may be beneficial for the fidelity reviewers and the IDDT Team Leader to review recommendations from the last fidelity review along with changes at the beginning of the fidelity review process. Such a reflection would provide historical information and give the fidelity reviewers an opportunity to evaluate and build on previous reviewer's perceptions of the program.

Finally, according to the perception of one participant, the model needs to be modified for different agencies. According to Rogers (1995), within an organization, changes or modifications of an original innovation are expected and occur due to complexity of an innovation, lack of knowledge about the innovation, or lack of monitoring. Although slight deviations from the original model may be acceptable, it may be beneficial for CCOE staff to ensure that providers genuinely have the necessary

knowledge about the IDDT model along with an understanding of the importance of adherence to fidelity. This knowledge may minimize modification of the original model in practice.

Implications for the Counseling Field

The findings in this study are consistent with the literature on implementation. They present implications for both counselor education and the counseling field in general. Within the realm of counselor education, the lack of knowledgeable providers about evidence-based practice can be addressed through the modification of current curricula or the addition of coursework. Within the counseling field, the need for education about substance use and the need to work within the framework of a team are addressed.

Counselor Education

The lack of providers who are knowledgeable about not only integrated treatment (ATTC, 2005b; Azrin & Goldman, 2005) but also evidence-based treatment in general (Isett et al., 2007) is notable. This lack of providers makes it difficult for agencies to find staff who can implement an evidence-based practice. Clinicians who are hired to work within the framework of an evidence-based practice without formal knowledge may experience a learning curve that delays successful implementation. In addition, these clinicians may be unable to grasp the concepts of the model.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) was established to accredit counseling and related educational programs and is committed "to the development of standards and procedures that reflect the needs of a

dynamic, diverse and complex society" (CACREP, 2008b). At the time of the current study, the 2001 preparation standards were in effect for programs that had obtained, or were pursuing, CACREP accreditation, and 2009 proposed standards were being finalized. Within the 2001 preparation standards, evidence-based practice was not addressed (CACREP, 2001). However, as part of the common core curricular experiences in the 2009 proposed standards revision, programs need to provide evidence that students are knowledgeable about outcome-based research and research that is used to inform evidence-based practice (CACREP, 2008a). In addition to the common core curricular experiences, programs that prepare individuals who wish to work as addiction counselors, clinical mental health counselors, or marriage, couple, and family counselors need to provide evidence that students are knowledgeable about evidence-based treatment and have a basic understanding of evaluation of counseling outcomes.

To address the lack of knowledgeable providers, programs that prepare counseling and related professionals that are pursuing or have CACREP accreditation will need to incorporate education about evidence-based practice into existing coursework. However, because of the number of evidence-based practices that are currently available, along with the complexity of each practice (e.g., specific fidelity requirements), integrating evidence-based practice into existing coursework may not be feasible. In addition, a brief overview of evidence-based practice may not adequately prepare a professional to work within the construct of the practice. If the participants in the current study had been trained on evidence-based practice, their perception of the implementation process may not have entailed such a steep learning curve. In order to

increase professional competence and prepare students to work within the construct of an evidence-based practice, it would be beneficial for programs to add a required course that directly addresses current evidence-based practices. Having knowledge of evidence-based practice is a useful tool for clinicians and broadens employment opportunities upon graduation.

Practice of Counseling

One implication for the practice of counseling is the need to be knowledgeable about and competent in the treatment of substance use. According to the research, there is a lack of providers who are able to detect a substance use diagnosis (Drake, Morse, et al., 2004; Mueser et al., 1998). This is disconcerting considering the prevalence of substance use among individuals who present with mental health problems. According to R. M. Miller and Brown (1997), all mental health service providers should have knowledge of and competency to address and recognize substance abuse.

In the CACREP 2001 program standards, knowledge of addictive behavior is briefly mentioned in the common core curricular experiences (CACREP, 2001). Substance abuse is also briefly mentioned in the standards for programs that prepare individuals for work as college counselors, gerontological counselors, school counselors, and student affairs professions. In the proposed standards revision for 2009, CACREP expanded the common core curricular experiences to include knowledge of "theories and etiology of addictions and addictive behaviors including strategies for prevention, intervention and treatment" (CACREP, 2008a, p. 10). In addition to the common core curricular experiences, knowledge of substance use was expanded in programs that

prepare individuals for work as clinical mental health counselors and marriage, couple, and family counselors. It is interesting to note that for mental health counseling programs, the terminology related to substance abuse was modified for the 2009 standards. Within the 2001 CACREP standards for mental health counseling programs, knowledge and skill requirements for mental health counselors included, "General principles and practices of etiology, diagnosis, treatment, referral, and prevention of mental and emotional disorders and *dysfunctional* [italics added] behavior, including addictive behaviors" (CACREP, 2001, p. 26). The terminology in the 2009 standards was changed to "Knows the disease concept and etiology of chemical dependency and other addictions" (CACREP, 2008a, p. 29). The 2009 standards also address the need for individuals who are preparing to work as addiction counselors to recognize "the potential for substance use disorders to mimic a variety of medical and psychological disorders and the potential for medical and psychological disorders to co-exist with addiction and substance abuse" (CACREP, 2008a, p. 17).

Programs that prepare counseling and related professionals that are pursuing or have CACREP accreditation will need to incorporate education about substance use into existing coursework. Because of the prevalence of substance use, a course dedicated to substance use is warranted within the required coursework of all programs preparing students in counseling and related educational programs. Such a course would potentially eliminate the separation of treatment (i.e., mental health and substance use) and allow the provider to treat clients with problems related to substance use, eliminating the need to refer to other providers. By maintaining awareness of the prevalence of substance use and

its affect on the individual, the counselor can work within a holistic approach and intentionally integrate all aspects of treatment.

Another implication for the practice of counseling is the ability to work as a member of a team. The research supports the lack of teamwork or inter-professional dialogue present within community mental health agencies (Norman & Peck, 1999). The importance of teamwork cannot be underestimated and carries many benefits (e.g., reduced burnout, reduced isolation). In both the 2001 program standards and the proposed 2009 program standards for CACREP, the common core curricular experiences address the need for preparation programs to educate students about "Professional roles, functions, and relationships with other human service providers, including strategies for interagency collaboration and communication" (CACREP, 2008a, p. 9). In both the 2001 standards and the proposed 2009 program standards, students are required to learn about the role of a counselor as a member of a service provision team in various areas of specialization (e.g., career counseling, school counseling). Within mental health counseling, both standards address the need for students to be knowledgeable about interdisciplinary treatment teams and the role and function of both the counselor and other providers on the team (CACREP, 2001, 2008a). Surprisingly, interdisciplinary treatment teams are not mentioned within other domains of the preparation standards. Knowledge of one's role on a team does not adequately prepare practitioners to work within a multidisciplinary team. In fact, a lack of clearly defined roles within a multidisciplinary team may result in conflict among team members (Norman & Peck, 1999). Therefore, it is important to learn not only one's role but the role of other

providers who are involved in the care of a mutual client. Whether the counselor is in an agency that offers an array of services (e.g., psychiatry, nursing) or working independently, it is important to work with all treatment professionals who have interaction with a client. Furthermore, it is important for counselors to maintain awareness of differing treatment perspectives (e.g., biological versus psychosocial) and different philosophies (e.g., electroconvulsive therapy vs. antidepressant medication) that may impact client care. An understanding of these perspectives can possibly ease the process of collaboration. In sum, preparation programs need to educate students about not only the counselor's role on a service provision team but also the roles of individuals who typically represent various disciplines on a multidisciplinary team (e.g., psychiatry, psychology, nursing, social work).

Limitations

Within the current study, certain limitations must be acknowledged prior to making inferences from the data. Several limitations were present in the current study. The first limitation focuses on the participants in the current study. A limited number of Team Leaders in the state of Ohio were eligible to participate. Although the initial intent was to select participants throughout the state, numerous attempts were made to solicit participation, and only a limited number of Team Leaders willingly participated. Those individuals who chose to participate may have had a more favorable view of the model and implementation or may have had a more positive experience during the implementation process, resulting in a possible bias in the data. However, the participants

appeared to be objective about challenges during implementation and did not paint a perfect picture of implementation.

A second limitation within the current study was the possible need for participants to present themselves in a favorable light. According to Wiles, Charles, Crow, and Heath (2006), "Study participants in social research often choose to participate on the understanding or hope that their experiences will 'help' others in a similar situation" (p. 296). According to the authors, researchers often sell their research to participants under the auspices that findings will be used for policy, development of services, or helping others in the field (Wiles et al.). In the Consent to Participate form that was mailed to participants prior to inception of the study, the researcher clearly stated an interest in informing research on implementation. In addition, participants were informed that they would have the opportunity to read about how other IDDT Team Leaders have implemented the model. Therefore, the possibility that participants presented themselves in a favorable light to both the public and their peers was present. In addition, one of the participants in the current study moved into a different job role that may have been jeopardized by participation in the study.

Delimitations

The formal definition of delimit is "to fix or define the limits of" (Merriam-Webster, 2007). Certain restrictions created a boundary at the onset of the study. In the current study, the delimitations that were defined included generalizability and anonymity of participants.

According to D. T. Campbell and Stanley (1963), generalizability refers to the settings, treatment variables, populations, and measurement variables in which an effect can be generalized in quantitative research. Within qualitative research, the researcher focuses on universal statements of social processes instead of universal statements between settings that are similar (Bogdan & Biklen, 1998). The goal of a grounded theory study is to build a theory and "explain what might happen in given situations such as stigma, chronic illness, or closed awareness" (p. 267) and focuses on *predictive ability* within a context (Strauss & Corbin, 1998). In other words, the qualitative researcher is more interested in examining a situated context rather than generalizing findings to all settings. Therefore, it cannot be stated with confidence that findings in the current study are generalizable. In addition, representativeness is basic to generalizability (Lincoln & Guba, 1985). Because of the difficulty eliciting participation in the current study, the individuals who did participate may not be representative of all IDDT Team Leaders, thereby raising the question of whether or not replication of the current study would produce the same results.

The use of anonymity removes identifying information from the data with the purpose of protecting the privacy of research participants (Thomson, Bzdel, Golden-Biddle, Reay, & Estabrooks, 2005). The extent to which data is amended to maintain anonymity is debatable (Wiles et al., 2006). According to the American Counseling Association Code of Ethics (2005), every effort must be made on the part of the researcher to protect participants from harm caused by participation in a study. In the current study, the consent to participate letter that was sent to participants prior to the

study guaranteed confidentiality and anonymity. Therefore, anonymity was a necessary prerequisite. Pseudonyms were used for research participants and other identifying information (e.g., agency names, location) was removed. According to Lincoln and Guba (1985), despite the researcher's attempt at anonymity, data often give clues to identity and if familiar with the site, the reader may be able to identify participants. Although necessary, anonymization is questioned in the literature. According to Thomson et al. (2005), by removing identifying information, the researcher also removes contextual information. In the current study, every effort was made to keep the original data in context.

Recommendations for Theory and Research

Several recommendations for future research on implementation are presented in this section. Findings of this study generated a substantive theory of implementation as a multi-dimensional process from the perspective of 6 IDDT Team Leaders. Research to date has focused on implementation at the national, (Isett et al., 2007; McHugo et al., 2007), state (ODMH, 2007a), and agency (Wieder et al., 2007) levels. The majority of research has focused on the national and state level, leaving a dearth of research on implementation at the agency level, specifically with IDDT Team Leaders. The majority of findings from the current study build on existing research on aspects of implementation at a macro (e.g., systems) level; however, future research on a micro (e.g., provider) level is warranted. These recommendations at a micro level include research on Team Leader leadership skills, the interaction of the model and leadership

characteristics, Team Leader impact on fidelity scores, and characteristics of providers on an IDDT team.

According to the findings in this study, the participants developed leadership characteristics that are defined as effective in the literature (Glaser, 2006; Kouzes & Posner, 2002; Zauderer, 2005). Future research focused on an exploration of whether or not IDDT Team Leaders develop these characteristics or have effective leadership characteristics prior to taking on the role of team leader is warranted. In addition, the development of an instrument focusing on leadership characteristics may be helpful in the IDDT Team Leader selection process. This particular recommendation is consistent with Boyle and Wieder's (2007) observation of implementation in the state of Ohio.

Another recommendation for future research expands on the previous recommendation. Results of the current study demonstrated that the participants integrated aspects of the IDDT model, along with effective leadership characteristics as defined in the literature, into their daily interactions with others. This begs the question of whether aspects of the model create good leaders or if leaders with specific characteristics (e.g., leading a responsible life of deputyship; Zauderer, 2005) are drawn to the IDDT model. Findings indicated that aspects of the model and characteristics of effective leadership appear to be intertwined. Further research focusing on this perceived phenomenon may be beneficial in selecting IDDT Team Leaders.

The fidelity scores for each of the respective programs were fairly high, ranging from 3.2 – 4.7 out of 5 on the fidelity scale. The question of whether the Team Leaders in the current study impacted fidelity ratings was beyond the scope of the current study.

Future research focused on whether the IDDT Team Leader directly impacts fidelity ratings is another recommendation for future research.

Finally, the last recommendation for future research is identification of individual characteristics in team members that are compatible with the IDDT model. In the current study, the participants identified characteristics that they looked for when hiring team members. Research dedicated to identification of characteristics is warranted in order to potentially streamline the process of hiring individuals who would work well within the IDDT team concept.

Experience of the Researcher

During the first round of interviews, the tone of the interviews was formal, and the participants did not appear to be relaxed. During the second round of interviews, the tone was more informal, and the participants appeared to welcome the opportunity to talk about their experiences of implementation. As a result, the second round of interviews lasted longer than the first round.

After each interview, the researcher wrote memos in order to reflect. What stood out most during the interviews with all of the participants was their passion about the clients, the model, and treatment in general. The researcher shared their passion and belief that individuals with severe mental illness can go through recovery if they choose to do so and if they have the support of others.

As the data were analyzed, the researcher became aware that many of the verbalized experiences of the participants were similar to yet different from her own experience with implementation. The conversations with the participants truly were a

conversation with a purpose and were helpful in conceptualizing the processes of implementation, providing the researcher with ways to change her own approach to implementation of the IDDT model.

Summary

Chapter 4 presented the findings in the current study. The purpose of this study was to generate a substantive theory about the process of implementation in order to address the gap in the literature on implementation of an evidence-based practice. The main and additional findings of the current study were analyzed and described. Implications for the Ohio SAMI CCOE and the counseling field were presented, along with the limitations and delimitations of the current study. Recommendations for theory and research were proposed, and the experience of the researcher was recounted.

Individual components within the model of implementation as a multi-dimensional process build on existing research on implementation at the macro level. It also builds on the limited research on implementation at the micro level and offers a new perspective on implementation. The framework of this model can be used to guide future research on implementation of the IDDT model from the perspective of front-line clinicians, specifically the IDDT Team Leader.

APPENDICES

APPENDIX A

IDDT FIDELITY SCALE RATING SHEET

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale

*Individual Rating Sheet**

_____	_____
Name of Chair	Program Reviewed
_____	_____
Name of Reviewer	Date of Site Visit

*Adapted by S. Leibbrandt and B. Wieder from the IDDT Fidelity Scale (Version 8/9/02-**R**) developed by the National Evidence-Based Practice Implementation Project.

Used with permission (SAMI CCOE, 2007)

PART I: ORGANIZATIONAL FACTORS

Item O1. Program Philosophy. The program is committed to a clearly articulated philosophy (assertive outreach, integrated mental health and substance abuse treatment, stage-wise interventions, comprehensive services, and a long-term perspective) consistent with IDDT, based on the following 5 data sources: Program leader, senior staff, clinicians, clients and/or families and written brochures.

O1. Program Philosophy	Rating	Rationale for Rating
1 of the 5 sources shows evidence of a clear understanding of the program philosophy	1	
2 of the 5 sources shows evidence of a clear understanding of the program philosophy	2	
3 of the 5 sources shows evidence of a clear understanding of the program philosophy	3	
4 of the 5 sources shows evidence of a clear understanding of the program philosophy	4	
5 of the 5 sources shows evidence of a clear understanding of the program philosophy	5	

Item O2. Eligibility/Client Identification. All clients with severe mental illness in the community support program, crisis clients and institutionalized clients are screened to determine whether they qualify for IDDT, using standardized tools or admissions criteria. Also, the agency tracks the number of eligible clients in a systematic fashion.
Data Sources: Interviews with the program leader, senior staff and clinicians; chart review

O2. Eligibility/Client Identification	Rating	Rationale for Rating
≤ 20% of clients receive standardized screening and/or agency DOES NOT systematically track eligibility	1	
21% - 40% of clients receive standardized screening and agency systematically tracks eligibility	2	
41% - 60% of clients receive standardized screening and agency systematically tracks eligibility	3	
61% - 80% of clients receive standardized screening and agency systematically tracks eligibility	4	
>80% of clients receive standardized screening and agency systematically tracks eligibility	5	

Item O3. Penetration. Penetration is the maximum number of eligible clients receiving IDDT, as defined by a ratio. ***The SAMI CCOE will calculate this ratio using your responses below. Please disregard the information in the shaded box.***
Data Sources: Interviews with the program leader and senior staff; review of strategic plan

1. How many adults with severe mental illness (SMI) disorders (e.g., Schizophrenia, Bipolar, severe Depression with or without psychosis, Psychosis NOS) are currently served by your agency _____?

2. How many clients at your agency are eligible for IDDT (i.e., have a co-occurring substance abuse disorder)? _____?

3. How many clients at your agency receive IDDT _____?

O3. Penetration	Rating	Rationale for Rating
Ratio < .20	1	
Ratio between .21 and .40	2	
Ratio between .41 and .60	3	
Ratio between .61 and .80	4	
Ratio > .80	5	

Item O4. Assessment. Full standardized assessment of all clients who receive IDDT services. Assessment includes history and treatment of medical/psychiatric/substance use disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.
Data Sources: Interviews with the program leader, senior staff and clinicians; chart review

O4. Assessment	Rating	Rationale for Rating
Assessment is completely absent or completely non-standardized	1	
The agency is seriously deficient in both criteria	2	
The agency is somewhat deficient in both criteria **OR** seriously deficient on one of the criteria	3	
61% - 80% of clients receive standardized assessment **OR** information is less than comprehensive across all assessment domains	4	
> 80% of clients receive standardized assessment **AND** the information is comprehensive across all assessment domains	5	

Item O5. Treatment Plan. For all clients receiving IDDT, there is a specified treatment plan *related to IDDT* for individualized treatment. This plan is consistent with the assessment and is updated every 3 months.
Data Sources: Interviews with the program leader, clinicians and clients; chart review; observation of team meeting/supervision

O5. Treatment Plan	Rating	Rationale for Rating
≤ 20% of clients receiving IDDT have a specified treatment plan, updated every 3 months	1	
21% - 40% of clients receiving IDDT have a specified treatment plan, updated every 3 months	2	
41% - 60% of clients receiving IDDT have a specified treatment plan, updated every 3 months	3	
61% - 80% of clients receiving IDDT have a specified treatment plan, updated every 3 months	4	
> 80% of clients receiving IDDT have a specified treatment plan, updated every 3 months	5	

Item O6. Treatment. Clients receive IDDT services consistent with their individualized treatment plan that is clearly *related to IDDT*.
Data Sources: Interviews with the program leader, clinicians and clients; chart review

O6. Treatment	Rating	Rationale for Rating
≤ 20% of clients served by IDDT receive services consistent with their treatment plan	1	
21% - 40% of clients served by IDDT receive services consistent with their treatment plan	2	
41% - 60% of clients served by IDDT receive services consistent with their treatment plan	3	
61% - 80% of clients served by IDDT receive services consistent with their treatment plan	4	
> 80% of clients served by IDDT receive services consistent with their treatment plan	5	

Item O7. Training. All new clinicians receive standardized training in IDDT (at least a 2-day workshop or its equivalent). Existing clinicians receive annual refresher training (at least 1-day workshop or its equivalent).
Data Sources: Interviews with the program leader, senior staff and clinicians; review of training curriculum, schedule and participation via human resources records

O7. Training	Rating	Rationale for Rating
≤ 20% of clinicians receive standardized training annually	1	
21% - 40% of clinicians receive standardized training annually	2	
41% - 60% of clinicians receive standardized training annually	3	
61% - 80% of clinicians receive standardized training annually	4	
> 80% of clinicians receive standardized training annually	5	

Item O8. Supervision. Clinicians receive weekly supervision (individual or group) *from a clinician experienced in IDDT.* Sessions explicitly address the IDDT model and its application.
Data Sources: Interviews with the program leader, senior staff and clinicians; observation of team meeting/supervision.

O8. Supervision	Rating	Rationale for Rating
≤ 20% of clinicians receive weekly supervision	1	
21% - 40% of clinicians receive weekly supervision	2	
41% - 60% of clinicians receive weekly supervision	3	
61% - 80% of clinicians receive weekly supervision	4	
> 80% of clinicians receive weekly supervision	5	

Item O9. Process Monitoring. Supervisors and program leaders monitor the process of implementing IDDT every 6 months and use the data to improve the program. Monitoring involves a systematic approach, e.g., fidelity scale, training and supervision activity, service/attendance data.
Data Sources: Interviews with the program leader, senior staff and clinicians; review of internal reports/documentation

O9. Process Monitoring	Rating	Rationale for Rating
No attempt at monitoring the process is made	1	
A non-systematic approach to monitoring is used at least annually	2	
A non-systematic approach to process monitoring is used at least semi-annually (twice a year)	3	
Systematic process monitoring occurs less frequently than semi-annually (twice a year)	4	
Systematic process monitoring occurs semi-annually (twice a year)	5	

Item O10. Outcome Monitoring. Supervisors/ program leaders monitor standardized outcomes for IDDT clients every 6 months and share the data with IDDT clinicians. Monitoring involves a standardized approach to assessing key outcomes related to IDDT, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.
Data Sources: Interviews with the program leader, senior staff and clinicians; review of internal reports/documentation, chart review (see ODMH Adult Form A, SATS, Cluster Form, progress notes, treatment plan)

O10. Outcome Monitoring	Rating	Rationale for Rating
No attempt at monitoring is made	1	
A non-standardized approach to monitoring is used at least annually	2	
A non-standardized approach to outcome monitoring is used at least semi-annually	3	
Standardized outcome monitoring occurs less frequently than semi-annually **AND** results are shared with IDDT clinicians	4	
Standardized outcome monitoring occurs semi- annually **AND** results are shared with IDDT clinicians	5	

Item O11. Quality Improvement (QI). The agency has a QI committee or representative with an explicit plan to review IDDT, or components of the program, every 6 months.
Data Sources: Interviews with the program leader and QI committee member

O11. Quality Improvement (QI)	Rating	Rationale for Rating
No review or no committee/representative	1	
Infrequent, disorganized QI review	2	
Occasional review, but not a regular, organized activity	3	
Explicit QI review occurs annually	4	
Explicit review every 6 months by a QI committee or representative	5	

Item O12. Client Choice. All clients receiving IDDT services are offered choices; the IDDT clinicians consider and abide by client preferences when offering and providing services.
Data Sources: Interviews with the program leader, clinicians and clients; observation of team meeting/supervision; chart review

O12. Client Choice	Rating	Rationale for Rating
Client-centered services are absent (or all IDDT decisions are made by staff)	1	
Few sources agree that type and frequency of IDDT services reflect client choice	2	
Half the sources agree that type and frequency of IDDT services reflect client choice	3	
Most services agree that type and frequency of IDDT services reflect client choice	4	
All sources agree that type and frequency of IDDT services always reflect client choice	5	

PART II: TREATMENT CHARACTERISTICS

Item T1a. Multidisciplinary Team: A multidisciplinary team consists of a DD clinician and two or more of the following: a physician, nurse, case manager and providers of ancillary services who *work collaboratively* on the mental health team. Collaboration suggests that team members regularly communicate about the client's progress and are not merely component parts.
Data Sources: Interviews with the ancillary service providers, clinicians and clients; chart review

T1a. Multidisciplinary Team	Rating	Rationale for Rating
≤ 20% of clients receive care from a multidisciplinary team	1	
21% - 40% of clients receive care from a multidisciplinary team	2	
41% - 60% of clients receive care from a multidisciplinary team	3	
61% - 79% of clients receive care from a multidisciplinary team	4	
≥ 80% of clients receive care from a fully multidisciplinary team with a strong emphasis on accessing a broad range of services and excellent communication between all disciplines	5	

Item T1b. Integrated Substance Abuse Specialist. Substance abuse specialist, having at least two years experience, works collaboratively with the treatment team.
Data Sources: Interviews with clinical supervisor, clinicians, QI staff and clients; chart review

T1b. Integrated Substance Abuse Specialist	Rating	Rationale for Rating
No substance abuse specialist connected with agency	1	
Dual disorder clients are referred to a separate substance abuse department within the agency (e.g., referred to drug and alcohol staff)	2	
Substance abuse specialist serves as a consultant to treatment team; does not attend meetings; is not involved in treatment planning	3	
SA specialist is assigned to the team, but is not fully integrated; attends some meetings; may be involved in treatment planning but not systematically	4	
SA specialist is a fully integrated member of the treatment team; attends all team meetings; involved in treatment planning for DD clients	5	

Item T2. Stage-Wise Interventions. Treatment is consistent with the client's stage of recovery (engagement, persuasion, action, relapse prevention)
Data Sources: Interviews with clinical supervisor, clinicians, clients and QI staff; chart review

T2. Stage-Wise Interventions	Rating	Rationale for Rating
Clinicians do not know or apply this framework **OR** ≤ 20% of interventions are consistent with client's stage of recovery	1	
Less than half of clinicians have a vague awareness of stages **AND** 21% - 40% of interventions are consistent with client's stage of recovery	2	
Less than half of clinicians have a good awareness of stages **AND** 41% - 60% of interventions are consistent with client's stage of recovery	3	
Most clinicians are knowledgeable but only 61%-79% of interventions are consistent with client's stage of recovery	4	
All clinicians understand stage-wise framework, know which stage each client is in, **AND** ≥ 80% of interventions are consistent with client's stage of recovery	5	

Item T3. Access to Comprehensive DD Services. To address a range of needs of clients with DD, the agency offers residential service, supported employment family psychoeducation, illness management and ACT or ICM.
Data Sources: Interviews with the program director/coordinator, clinicians and ancillary service providers; chart review

T3. Access to Comprehensive DD Services	Rating	Rationale for Rating
Less than 2 services are provided by the service provider	1	
2 services are provided by the service provider **AND** IDDT clients have genuine access to these services	2	
3 services are provided by the service provider **AND** IDDT clients have genuine access to these services	3	
4 services are provided by the service provider **AND** IDDT clients have genuine access to these services	4	
All 5 services are provided by the service provider **AND** IDDT clients have access within two months of referral to these services	5	

Item T4. Long-Term Services. Clients with DD are treated on a time unlimited basis with intensity modified according to need and degree of recovery. Examples of these services include: substance abuse counseling, residential services, supported employment, family psychoeducation, illness management and ACT or ICM.
Data Sources: Interviews with the program director/coordinator, clinicians and ancillary service providers

T4. Long-Term Services	Rating	Rationale for Rating
≤ 20% of services are provided on a time unlimited basis (e.g., clients are closed out of most services after a defined period of time)	1	
21% - 40% of services are provided on a time unlimited basis	2	
41% - 60% of services are provided on a time unlimited basis	3	
61% - 79% of services are provided on a time unlimited basis	4	
≥ 80% of services are provided on a time unlimited basis with intensity modified according to each client's needs	5	

Item T5. Outreach. Clinicians provide DD clients in Engagement stage (see **Item T2**) with assertive outreach, characterized by some combination of meetings and practical assistance.
Data Sources: Interviews with the ancillary service providers, clinicians and clients

T5. Outreach	Rating	Rationale for Rating
Program is passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	1	
Program makes initial attempts to do outreach but generally focuses efforts on most motivated clients	2	
Program attempts outreach and uses legal mechanisms only as convenient	3	
Program usually has plan for outreach and uses most of the mechanisms that are available	4	
Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate	5	

Item T6. Motivational Interventions. All interactions with DD clients are based on motivational interviewing techniques.
Data Sources: Interviews with clinicians, clients; observations of team meeting/ supervision

T6. Motivational Interventions	**Rating**	**Rationale for Rating**
Clinicians do not understand motivational interventions **AND** ≤ 20% of interactions with clients are based on motivational approaches	1	
Some clinicians understand motivational interventions **AND** 21% - 40% of interactions with clients are based on motivational approaches	2	
Most clinicians understand motivational interventions **AND** 41% - 60% of interactions with clients are based on motivational approaches	3	
All clinicians understand motivational interventions **AND** 61% - 79% of interactions with clients are based on motivational approaches	4	
All clinicians understand motivational interventions **AND** ≥ 80% of interactions with clients are based on motivational approaches	5	

Item T7. Substance Abuse Counseling. Clinicians demonstrate understanding of the basic substance abuse principles.
Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T7. Substance Abuse counseling	**Rating**	**Rationale for Rating**
Clinicians do not understand basic substance abuse counseling principles **AND** ≤ 20% of clients in active treatment stage or relapse prevention stage receive SA counseling	1	
Some clinicians understand basic SA counseling principles **AND** 21% - 40% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	2	
Most clinicians understand basic SA counseling principles **AND** 41% - 60% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	3	
All clinicians understand basic SA counseling principles **AND** 61% to 79% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	4	
All clinicians understand basic SA counseling principles **AND** ≥ 80% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	5	

Item T8. Group Dual Disorder Treatment. All clients with DD are offered a group treatment specifically designed to address both mental health and substance abuse problems, and approximately two-thirds are engaged regularly (i.e., at least weekly) in some type of peer- oriented group. Groups could be family, persuasion, psychoeducation or social skills.
Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T8. Group DD Treatment	Rating	Rationale for Rating
< 20% of clients regularly (i.e., at least weekly) attend a DD group	1	
20% - 34% of clients regularly (i.e., at least weekly) attend a DD group	2	
35% - 49% of clients regularly (i.e., at least weekly) attend a DD group	3	
50% - 65% of clients regularly (i.e., at least weekly) attend a DD group	4	
Two-thirds or more of clients regularly (i.e., at least weekly) attend a DD group	5	

Item T9. Family Dual Disorder Treatment. Where available and if the client is willing, clinicians always attempt to involve family members (or long-term social network/significant others). The purpose is to give psychoeducation about DD and coping skills to reduce stress in the family, and to promote collaboration with the treatment team. Percentage is based on the number of family/social supports in contact with the provider.
Data Sources: Interviews with the program director/coordinator, clinicians and clients; chart review

T9. Family DD Treatment	Rating	Rationale for Rating
< 20% of families (or friends/significant others) receive psychoeducation on dual disorder	1	
20% - 34% of families (or friends/significant others) receive psychoeducation on dual disorder	2	
35% - 49% of families (or friends/significant others) receive psychoeducation on dual disorder	3	
50% - 65% of families (or friends/significant others) receive psychoeducation on dual disorder	4	
Two-thirds or more of families (or friends/ significant others) receive psychoeducation on dual disorder	5	

Item T10. Self-Help Liaison. Clinicians connect clients in the active stage or relapse prevention stage with substance abuse self-help programs in the community, such as Alcoholics Anonymous, Narcotics Anonymous, Rational Recovery Anonymous, Double Trouble or Dual Recovery Anon.
Data Sources: Interviews with the program director/coordinator and clinicians; chart review

T10. Self-Help Liaison	Rating	Rationale for Rating
< 20% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	1	
20% - 34% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	2	
35% - 49% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	3	
50% - 65% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	4	
Two-thirds or more of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	5	

Item T11. Pharmacological Treatment. Physicians or nurses prescribing medications are trained in dual disorder treatment and work with the client and the IDDT team to increase medication adherence, to decrease the use of potentially addictive medications and to offer medications such as clozapine, disulfiram, or naltrexone to help reduce addictive behavior. (**SU** = substance use).
Data Sources: Interviews with the medication prescriber (if available) and clinicians; chart review

T11. Pharmacological Treatment	Rating	Rationale for Rating
Prescribers are not trained in DD treatment, prescribe without input regarding substance use (doctor outside treatment team) **OR** require abstinence prior to prescribing psychiatric meds.	1	
A minority of prescribers are trained in DD and there is minimal contact with treatment team; no efforts to ↑ adherence or to ↓ SU, using meds.	2	
About half of prescribers are trained in DD but few prescribers work with team/client to increase adherence and reduce substance use	3	
All prescribers have DD training but have minimal input from IDDT team to maximize adherence; there is evidence of efforts to ↓ addictive meds.	4	
All prescribers are trained in DD and work with clients/IDDT team to ↑ adherence; use of anti-psychotics if necessary; offer meds known to be effective in decreasing substance use	5	

T12. Interventions to Reduce Negative Consequences. *Negative consequences* of substance abuse include the physical effects, social effects, effects on self-care and independent functioning and the use of substances in unsafe situations. *Interventions* consist of needle exchange programs, teaching safe sex practice, supporting clients who switch to less harmful substances, providing support to families, helping clients avoid high-risk situations for victimization, "safe driver" programs and securing housing that recognizes clients' ongoing substance abuse problems.
Data Sources: Interview with the program director/coordinator, clinicians and clients

T12. Interventions to ↓ Neg. Consequences	**Rating**	**Rationale for Rating**
Staff offer no form of education on reducing negative consequences	1	
There is no structured program; staff may know some ways of reducing negative consequences but rarely use these interventions	2	
Less than half of all DD clients receive a structured educational program on reducing neg. consequences; individual staff do not use interventions systematically	3	
50% - 79% of clients receive a structured educational program on reducing negative consequences; all staff are well-versed in techniques of reducing negative consequences	4	
≥ 80% of clients receive a structured basic education on how to reduce negative consequences; all staff are well-versed in techniques to reduce negative consequences.	5	

T13. Secondary Interventions for Treatment Non-Responders. The program has a specific plan to identify non-responders, to evaluate them for secondary, more intensive interventions, and to link them with appropriate secondary interventions. Secondary interventions might include arranging supervised housing, intensive family interventions, and residential treatment.
Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T13. Secondary Interventions	**Rating**	**Rationale for Rating**
≤ 20% of non-responders are evaluated **AND** referred for secondary interventions	1	
21% - 40% of non-responders are evaluated **AND** referred for secondary interventions	2	
41% - 60% of non-responders are evaluated **AND** referred for secondary interventions	3	
61% - 79% of non-responders are evaluated **AND** referred for secondary interventions	4	
≥ 80% of non-responders are evaluated **AND** referred for secondary intervention	5	

APPENDIX B

IDDT FIDELITY SCALE DEFINITIONS

IDDT FIDELITY SCALE – ITEM DEFINITIONS, RATIONALE AND DATA SOURCES

PART I: Organizational Characteristics

O1. Program Philosophy

Definition: The program is committed to a clearly articulated philosophy (assertive outreach, integrated mental health and substance abuse treatment, stage-wise interventions, comprehensive services, and a long-term perspective) consistent with IDDT.

Rationale: In mental health rehabilitation programs that truly embrace the best practices, staff members at all levels embrace the program philosophy and practice it in their daily work.

Data Sources: Interviews with the program leader, senior stag (e.g., executive director, psychiatrists), clinicians, clients and/or family members; review of written materials (brochures)

O2. Eligibility/Client Identification

Definition: All clients in the community support program, crisis clients, and institutionalized clients are screened using standardized tools or admission criteria.

- The *target population* refers to all adults with severe mental illness disorders served by the provider agency (i.e., Schizophrenia, Bipolar, severe Depression with or without psychosis, and Psychosis NOS). If the agency serves clients at multiple sites, then assessment is limited to the site or sites that are targeted for IDDT. If the target population is served in discrete programs (e.g., case management, day treatment, residential, etc.), then ordinarily all adults with severe mental illness are included in this definition.
- *The intent is to identify any and all who could benefit from the IDDT*. For integrated dual disorder treatment, the admission criteria are specified and specific assessment tools are recommended. In every case, the program should have an explicit, systematic method for identifying the eligibility of every client.
- *Screening* typically occurs at program admission, but for a program that is newly adopting IDDT, there should be a plan for systematically reviewing clients already active in the program.

Used with permission (SAMI CCOE, 2007)

Rationale: Accurate identification of clients who would benefit most from IDDT requires routine review for eligibility.

Data Sources: Interviews with the program leader, senior staff and clinicians; chart review

O3. Penetration

Definition: Penetration is the maximum number of eligible clients receiving IDDT, as defined by a ratio (calculated by the SAMI CCOE):

# of clients receiving an IDDT
divided by
# of clients eligible for the IDDT

All clients who could benefit from IDDT have access to IDDT.

Rationale: Surveys have repeatedly shown that access is very limited to IDDT and most other EBP's. The goal of dissemination of IDDT is not simply to create small exclusive programs but to make these practices easily accessible within the public mental health system.

Data Sources: Interviews with the program leader, senior staff; review of strategic plan for agency

O4. Assessment

Definition: All severely mentally ill clients receive a full, standardized assessment that is updated at least yearly. Assessment includes history and treatment of medical, psychiatric, and substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.

Rationale: Comprehensive assessment/re-assessment is indispensable in identifying target Domains of functioning that may need intervention, in addition to the client's progress toward recovery.

Data sources: Interviews with the program leader, senior staff and clinicians; chart review

O5. Treatment Plan

Definition: For all severely mentally ill clients, there is a specified treatment plan for individualized treatment consistent with the assessment that is updated every 3 months. Specificity refers to treatment recommendations that identify both the target of the

intervention (e.g., specific symptoms, social problems, substance abuse behaviors) and an intervention designed to address that problem and how it will bring about changes.

Rationale: Core values of IDDT include individualization of services and supporting clients' pursuit of their goals and progress in their recovery at their own pace. Therefore, the treatment plan needs ongoing evaluation and modification with consumer input.

Data Sources: Interviews with the program leader, clinicians and clients; chart review; observation of team meeting/supervision

O6. Treatment

Definition: All IDDT clients receive treatment consistent with their individualized treatment plan clearly *related to IDDT*.

Rationale: The key to the success of IDDT is an individualized treatment plan that is implemented in a timely fashion.

Data Sources: Interviews with the program leader, clinicians and clients; chart review.

O7. Training

Definition: All new clinicians receive standardized training in IDDT (at least a 2-day workshop or its equivalent). Existing clinicians receive annual refresher training (at least 1-day workshop or its equivalent). All clinicians who might provide some aspect of IDDT are to be considered as eligible for training.

Rationale: Clinician training and retraining are warranted to ensure that IDDT services are provided in a standardized manner.

Data Sources: Interviews with the program leader, senior staff and clinicians; review of training curriculum, schedule and participation via human resources records

O8. Supervision

Definition: Clinicians receive weekly supervision (individual or group) from a clinician experienced in IDDT. Sessions explicitly address the IDDT model and its application.

Rationale: Regular supervision is critical not only for individualizing treatment, but also for ensuring the standardized provision of IDDT services.

Data Sources: Interviews with the program leader, senior staff and clinicians; observation of team meeting/supervision

O9. Process Monitoring

Definition: Supervisors/program leaders monitor the process of implementing IDDT every 6 months and use the data to improve the program. Process monitoring involves a systematic approach, e.g., use of a fidelity scale, training, supervision, or examination of data on service use, group attendance or minutes from implementation committee meetings.

Rationale: Systematic and regular collection of process data is imperative to evaluating program fidelity.

Data Sources: Interviews with the program leader, senior staff and clinicians; review of internal reports/documentation

O10. Outcome Monitoring

Definition: Supervisors/program leaders monitor the outcomes of IDDT clients every 6 months and share the data with IDDT practitioners in an effort to improve services. Outcome monitoring involves a systematic approach to assessing clients, e.g., psychiatric admissions, a substance abuse treatment scale, number of job placements, MACSIS, or ODMH tools.

Rationale: Systematic and regular collection of outcome data is imperative to evaluating program effectiveness. Effective programs also analyze such data to ascertain what is working and what is not working, and use the results to improve the quality of services they provide.

Data Sources: interviews with the program leader, senior staff and clinicians; review of internal reports/ documentation, chart review (see ODMH Adult Form A, SATS, Cluster Form, progress notes, treatment plan)

O11. Quality Improvement (QI)

Definition: The agency's QI committee or representative has an explicit plan to review IDDT progress or components of the program every 6 months.

Rationale: Research has shown that programs that most successfully implement IDDT have better outcomes. Again, systematic and regular collection of process and outcome data is imperative to evaluating program effectiveness.

Data Sources: Interviews with the program leader and QI committee members/ representative

O12: Client Choice

Definition: All clients receiving IDDT services are offered choices; IDDT clinicians Consider and abide by client preferences when offering and providing services.

Rationale: A major premise of IDDT is that clients are capable of playing a vital role in the management of their illnesses and in making progress towards achieving their goals. Providers accept the responsibility of getting information to clients so that they can become more effective participants in the treatment process.

Data Sources: Interviews with the program leader, clinicians and clients; observation of team meeting/supervision; chart review

PART II: Treatment Characteristics

T1.a) Multidisciplinary Team

Definition: All clients with DD receive care from a multidisciplinary team that includes DD expertise. A multidisciplinary team consists of a DD clinician and two or more of the following: a physician, nurse, case manager and providers of ancillary services who *work collaboratively* on the mental health team. Collaboration suggests that team members regularly communicate about the client's progress and are not merely component parts.

Rationale: Although a major focus of treatment is the elimination or reduction of substance abuse, this goal is more effectively met when other domains of functioning in which clients are typically impaired are also addressed. Competent IDDT programs coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner.

Data Sources: Interviews with the ancillary service providers, clinicians and clients; chart review

T1.b) Integrated Substance Abuse Specialist

Definition: A substance abuse specialist who has at least 2 years of experience works collaboratively with treatment team. The experience can be in a variety of settings, preferably working with clients with a dual disorder, but any substance abuse treatment experience will qualify for rating this item.

Rationale: Having an experienced substance abuse specialist integrated into the treatment team is essential for ensuring a sustained focus on substance use.

Data Sources: Interviews with program leader, clinician, substance abuse specialist; chart review

T2. Stage-Wise Interventions

Definition: All interventions (including ancillary services) are consistent with and Determined by the client's stage of treatment or recovery. The concept of stages of treatment include:

1) ***Engagement***: Regular contact is maintained with agency staff
2) ***Persuasion***: Helping the engaged client develop the motivation to participate in recovery-oriented interventions.

3) ***Action***: Helping the motivated client acquire skills and supports for managing illnesses and pursuing goals.
4) ***Relapse Prevention***: Helping clients in stable remission develop and use strategies for maintaining recovery.

Rationale: Research suggests that modifications in maladaptive behavior occur most effectively when stages of treatment are taken into account.

Data Sources: Interviews with clinical supervisor, clinicians, clients and QI staff; chart review

T3. Access to Comprehensive DD Services

Definition: To address a range of needs of clients with DD, the agency offers the following five ancillary services. (For a service to be considered "available," it must both exist and be accessible by clients with DD, with needs met within 2 months of referral):

1) ***Residential service***: Supervised residential services that accept clients with DD, including supported housing (i.e., outreach for housing purposes to clients living independently) and residential programs with on-site residential staff. Exclude short-term residential services (i.e., a month or less).
2) ***Supported Employment***: Vocational program that stresses competitive employment in integrated community settings and provides ongoing support.
3) ***Family Psychoeducation***: A collaborative relationship between the treatment team and family (or significant others) that includes basic psychoeducation about SMI and its management, social support and empathy, interventions targeted to reducing tension and stress in the family as well as improving functioning in all family members.
4) ***Illness Management***: Systematic provision of necessary knowledge and skills through psychoeducation, behavioral tailoring, coping skills training and a cognitive-behavioral approach, to help clients learn to manage their illness, find their own goals for recovery, and make informed decisions about their treatment.
5) ***Assertive Community Treatment (ACT)*** or **Intensive Case Management (ICM)**: A multidisciplinary team (client-to-clinician ratios of 15:1 or lower) providing 24-hour care, at least 50% of the time in the community.

Ancillary services are consistent with IDDT philosophy and stages of treatment/recovery. For example, a housing program encompasses approaches for clients who are in engagement and motivation stages of recovery.

Rationale: Individuals with DD have a wide range of needs, such as developing a capacity for independent living, obtaining employment or some other meaningful activity, improving the quality of their family and social relationships, and managing

anxiety and other negative moods. Competent IDDT programs must be comprehensive because the recovery process occurs longitudinally in the context of making many life changes.

Data Sources: Interviews with the program director/coordinator, clinicians, and ancillary service providers; chart review

T4. Long-Term Services

Definition: Clients with DD are treated on a time unlimited basis with intensity modified according to need and degree of recovery.

Rationale: The evidence suggests that both disorders tend to be chronic and service. A time unlimited service that meets individual client's needs is believed to be the most effective strategy for the population.

Data Sources: Interviews with the program director/coordinator, clinicians and ancillary service providers

T5. Outreach

Definition: Clinicians provide clients with DD in the *Engagement* stage (see **Item T2**) with assertive outreach, characterized by some combination of meetings and practical assistance (e.g., housing, medical care, crisis management, legal aid, etc.) in their natural living environments as a means of developing trust and a working alliance. Other clients continue to receive outreach as needed.

Rationale: Many clients with DD tend to drop out of treatment due to the chaos in their lives, low motivation, cognitive impairment, and hopelessness. Effective IDDT programs use assertive outreach to keep the clients engaged.

Data Sources: Interviews with the ancillary service providers, clinicians and clients

T6. Motivational Interventions

Definition: All interactions with dual disorder clients are based on motivational interviewing that include:

1) ***Expressing empathy.***
2) ***Developing discrepancy between goals and continued use.***
3) ***Avoiding argumentation.***
4) ***Rolling with resistance.***
5) ***Instilling self-efficacy and hope.***

Rationale: Motivational interviewing involves helping the client identify his/her own goals and to recognize, through a systematic examination of the individual's ambivalence, that not managing one's illnesses interferes with attaining those goals. Research has demonstrated that clients with DD who are unmotivated can be readily identified and effectively helped with motivational interventions.

Data Sources: Interviews with clinicians and clients; observations of team meeting/supervision

T7. Substance Abuse Counseling

Definition: Clinicians demonstrate understanding of basic substance abuse principles. Clients who are in the *action* stage or *relapse prevention* stage receive substance abuse Counseling aimed at:

1) Teaching how to manage cravings;
2) Teaching relapse prevention strategies;
3) Problem-solving skills training to avoid high-risk situations;
4) Challenging clients' beliefs about substance use; and
5) Coping skills training to deal with symptoms or negative mood states related to substance abuse (e.g., relaxation training, teaching sleep hygiene, cognitive-behavioral therapy for depression or anxiety, coping strategies for hallucinations)

The counseling may take different forms and formats, such as individual, group (including 12-Step based treatment programs), or family therapy or a combination thereof.

Rationale: Once clients are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Effective IDDT programs provide some form of counseling that promotes cognitive-behavioral skills at this stage.

Data Sources: Interviews with the program director/coordinator, clinicians and clients; chart review.

T8. Group DD Treatment

Definition: All clients with DD are offered a group *treatment* specifically designed to address both mental health and substance abuse problems, and approximately two-thirds are engaged regularly (e.g., at least weekly) in some type of peer-oriented group. Groups could be family, process-oriented persuasion or active treatment, psychoeducation, relapse prevention or social skills.

Rationale: Research indicates that better outcomes are achieved when group treatment

is integrated to address both disorders. Additionally, the group format is an ideal setting for clients to share experiences, support, and coping strategies.

Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T9. Family DD Treatment

Definition: Where available and if the client is willing, clinicians *always attempt* to involve family members (or long-term social network/significant others) to give psychoeducation about DD and coping skills to reduce stress in the family, and to promote collaboration with the treatment team. Percentage is based on the number of family/social supports in contact with the provider.

Rationale: Research has shown that social support plays a critical role in reducing relapse and hospitalization in persons with SMI, and that family psychoeducation can be an especially powerful approach for improving substance abuse outcomes in clients with SMI. However, the decision to involve significant others is the client's choice. Clinicians should discuss the benefits of family treatment with the client, and respect his/her decision about whether and in what ways to involve them.

Data Sources: Interviews with the program director/coordinator, clinicians and clients; chart review

T10. Self-Help Liaison:

Definition: Clinicians connect clients in the *active* stage or *relapse prevention* stage with substance abuse self-help programs in the community, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Rational Recovery Anonymous (RRA), Double Trouble, Cocaine Anonymous (CA) or Dual Recovery Anonymous.

Rationale: Although pressuring reluctant clients to participate in self-help groups is contraindicated, social contacts with other members of self-help groups play an important role in the recovery of clients with DD, who are motivated to achieve or maintain abstinence.

Data Sources: Interviews with the program director/coordinator and clinicians; chart review

T11. Pharmacological Treatment:

Definition: Physicians or nurses prescribing medications are trained in DD treatment and work with the client and the IDDT team to increase medication adherence, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as clozapine, disulfiram, or naltrexone that may help reduce addictive behavior.

Rationale: Research indicates that psychotropic medications are effective in the treatment of SMI, including clients who have active substance abuse problems. Access to such medications including antipsychotics, mood stabilizers, and antidepressants is critical to effective treatment of SMI clients.

Data Sources: Interviews with the medication prescriber (if available) and clinicians; chart review

T12. Interventions to Reduce Negative Consequences:

Definition: Efforts are made to directly reduce the negative consequences of substance Abuse using methods other than substance use reduction itself. Typical negative consequences of substance abuse that are the focus of intervention include physical effects (e.g., disease, triggering mental illness relapses, prostitution involving unsafe sex), social effects (e.g., loss of family support, victimization), self-care and independent functioning (e.g., housing instability, incarceration, malnutrition), and use of substances in unsafe situations (e.g., driving while intoxicated). Examples of strategies designed to reduce negative consequences include: needle exchange programs, teaching safe sex practice, supporting clients who switch to less harmful substances, providing support to families, helping clients avoid high-risk situations for victimization, securing housing that recognizes clients' ongoing substance abuse problems, and "safe driver" programs.

Rationale: Clients with DD are at higher risk than general population for detrimental effects of substance abuse described above.

Data Sources: Interviews with the program director/coordinator, clinicians and clients.

T13. Secondary Interventions for Treatment Non-Responders:

Definition: The program has a specific plan to identify non-responders, to evaluate them for secondary more intensive interventions, and to link them with appropriate secondary interventions. Potential secondary interventions might include arranging supervised housing, intensive family interventions, protective payeeship, changing

medications, residential treatment, and conditional discharge.

Rationale: Consumers that do not effectively engage in or respond to the treatment plan may need a more intensive treatment experience that will provide any number of elements necessary for their recovery. In order to provide an adequate intensity of service, a protocol to identify, evaluate, and follow up with the client is necessary.

Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

APPENDIX C

KENT STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD APPROVAL

KENT STATE
UNIVERSITY

July 31, 2007

Vicki Montesano
ACHVE
White Hall

Re: 07-516 – "IDDT Team Leader Experiences of Implementing the Integrated Dual Disorder Treatment Model: A Grounded Theory"

Dear Ms. Montesano:

I am pleased to inform you that the Kent State University Institutional Review Board approved your Application for Approval to Use Human Research Participants as Level I, research. This application was approved on June 17, 2007 and is good for one year.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB further requests an annual report and a final report at the conclusion of the study.

A periodic review form will be sent following the marked end date of your protocol or within a year of the original date of approval of the application. Please complete the form and return it. If the project is expected to extend beyond the marked end date, please insert the new expected end date on the periodic review form. If the project is complete and **all data analysis has concluded**, please mark the appropriate box on the form. If data analysis is continuing, research is considered to be continuing. A copy of the periodic review form has been included for your awareness.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions, please contact me at 330.672.2704. (klight@kent.edu)

Sincerely,

Katherine Light

Katherine Light
IRB Administrator

APPENDIX D

SCREENING FORM

Screening Form

This form is used to determine whether participants have met eligibility criteria for the current study.

Participant Code: _____

1. Are you currently working as the IDDT Team Leader in the agency?

____ Yes ____ No

2. Are you and the agency actively working with the SAMI CCOE?

____ Yes ____ No

3. Has the IDDT program at your agency been in existence for at least one and a half years?

____ Yes ____ No

Best day and time to contact participant:

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

APPENDIX E

CONSENT TO PARTICIPATE AND AUDIO TAPE FORM

Consent to Participate

Consent Form: IDDT Team Leader Experiences of Implementing the Integrated Dual Disorder Treatment Model: A Grounded Theory

I am investigating the experiences of 6 Integrated Dual Disorder Treatment (IDDT) Team Leaders in Ohio who are currently implementing the IDDT model. Whether or not an evidence-based practice can be implemented and sustained is an important consideration for researchers and agencies considering the use of an evidence-based practice. I am interested in understanding the process of implementation, as well as informing research on implementation. I would like you to take part in this project.

If you decide to do so, you will be asked to participate in two separate individual and in-person interviews that will last approximately one to two hours each. I will come to your place of employment for these interviews, or we can meet at another location convenient for you. You will also be asked to review the audio-taped transcription from each interview to check for accuracy and make any changes that you feel are necessary. These reviews will be conducted on your own time after receiving the transcript from me 1 to 2 weeks after each interview. Both interviews will be audio recorded in order for me to capture all of the information that we discuss. You will also be asked to provide feedback about preliminary themes after all data have been gathered. You will receive a check for $20 after reviewing each transcript and $20 after providing feedback about preliminary themes. Therefore, there is the opportunity to earn a total of $60 at the end of the project.

All of the information that I gather from you will be kept confidential. Instead of using your name, I will be using a number for you in all documentation. In order to maintain your confidentiality, I will be referring to this number throughout the project. All information from this project will be stored in a secure location at Kent State University in 310 White Hall for three years after this project is completed.

If you take part in this project, you will have the opportunity to talk about your experiences of implementing the IDDT model. You will also have the opportunity to review the findings of this study and read about how other IDDT Team Leaders have implemented the model. Taking part in this project is entirely up to you, and no one will hold it against you if you decide not to participate. If you do take part, you may stop at any time without penalty.

If you want to know more about this research project, please call me at 330-421-6847. You can also contact the two faculty members who are co-directing this research

project, Jason McGlothlin, Ph.D., or Martin Jencius, Ph.D., at 330-672-2662. The project has been approved by the Kent State University Institutional Review Board for the Study of Human Subjects. If you have questions about Kent State University's rules for research, please call Peter Tandy, Ph.D., acting Vice President, Division of Research and Graduate Studies at 330-672-2704.

Enclosed is the consent to participate and audio tape form and a demographic questionnaire. If you agree to participate in this study, please complete the following page and sign on the three signature lines, complete the demographic questionnaire, and return these forms to me in the self-addressed stamped envelope. You will receive a copy of this consent form and the signature page.

Sincerely,

Vicki Montesano, Ed.S., PCCS, LICDC
Doctoral Candidate, Counseling and Human Development Services
Kent State University
Kent, OH 44242
330-421-6847
vlmksu@verizon.net

Consent to Participate and Audio Tape
Consent Form: IDDT Team Leader Experiences of Implementing the Integrated Dual Disorder Treatment Model: A Grounded Theory

I agree to take part in this project. I know what I will have to do and that I can stop at any time without incurring penalty. I understand that all information in this project will remain confidential.

_____
Signature Date

□ I agree to participate in two audio-recorded, in-person interviews (lasting 1 to 2 hours each) at a location of my choosing.

□ I agree to review the written transcript from each interview to check for accuracy

□ I agree to provide feedback about preliminary themes after all data have been gathered.

□ I would like a summary of the findings

I agree to audio taping at_____ on_____.

_____
Signature Date

I have been told that I have the right to hear the audio tapes before they are used. I have decided that I:

____want to hear the tapes ____do not want to hear the tapes

Sign now below if you do not want to hear the tapes. If you want to hear the tapes, you will be asked to sign after hearing them.

Vicki Montesano and other researchers approved by Kent State University □ **may** □ **may not** use the tapes made of me (please circle one). The original tapes or copies will be used for:

_____the research project described on page 1 of this mailing

_____
Signature Date

_____
Address

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE

IDDT Team Leader Experiences of Implementing the Integrated Dual Disorder Treatment
Model: A Grounded Theory

Demographic Questionnaire

In order to gather information about you and your agency, please provide the information requested below. Please note that instead of using your name, I will be assigning you a number and will refer to this number throughout the study. All information will be kept confidential.

Participant code: _____

1. Sex: Male_____ Female_____

2. Age _____

3. Race/Ethnicity_____

4. Highest Education Achieved _____

5. Professional License(s) and Certifications Held (spell out abbreviations, please)

_____

_____

6. Years of Experience in the Provision of Mental Health Services _____

7. In What Capacity Was This Experience _____

_____

8. Amount of Training on the IDDT model _____

_____

9. Number of Years as an IDDT Team Leader _____

10. Current Employer _____

11. Number of Years at Current Agency _____

12. When did Your Agency Adopt the IDDT Model? _____

13. Approximate Number of Employees at the Agency _____

14. Approximate Number of Clients Served Annually at the Agency _____

_____

15. Number of Members on IDDT Team _____

16. Number of Clients on IDDT Team _____

17. Is the *SAMI Matters* Newsletter Helpful for Your Ongoing Practice? _____

If so, in what way is it helpful? _____

_____

18. Is the SAMI CCOE Website Helpful for Your Ongoing Practice? _____

If so, in what way is it helpful? _____

_____

APPENDIX G

INTERVIEW PROTOCOL FOR SECOND INTERVIEW

SECOND INTERVIEW QUESTIONS
Participant One

What were the scores from your last fidelity review?

Organizational:
Treatment:

Interview question 1: Implementation

1. You had stated that the agency purposely sought out somebody to come in and construct the dual program at the agency. You had also said that the agency has always been client-centered even before they adopted the IDDT model.
   a. How does the philosophy of the model fit with the agency?

2. When you were discussing the IDDT model, you had said that working within the model reduced burn out and by setting manageable goals, it just made it feel better as a clinician.
   a. How does the philosophy of the model fit with you?

3. Other than a set agency protocol for implementation when you became team leader, what were some things that you changed?

4. When we met last time, I had asked how you felt your leadership style has impeded implementation. You stated that you like things to be done right and when they are not, you get discouraged. You stated that you struggle when your staff is at different stages and they are not doing things the right way.
   a. What areas of leadership do you feel you need to work on that would have helped during implementation?

5. When we talked last time, you had stated that the standards of productivity aren't set up to be supportive of doing an evidence-based practice. You had also stated that you wish that there was something that somebody could do as far as getting dual recognized as an actual service because IDDT is a program but you can't bill a dual diagnosis service.
   a. How do the agency, county, or State expectations impact implementation?
   b. How are you able to implement the model despite the barriers?

6. You had said that you felt you need to have the right people on the team: individuals who have a heart for individuals with co-occurring disorders. You also stated that with this population, you believe that you either have it or you don't in terms of being successful.
   a. How would you describe a person who "fits" or "gets" the model?

7. How do you think the philosophy of the model impacts or shapes the team?

8. You had said that the agency intentionally sought out an individual to implement the model, yet you also talked about productivity standards and being set up to fail.
   a. Overall, how does administration affect implementation?

9. You mentioned that you were asked to be on the team
   a. Tell me about your process of becoming leader and what it was like for you

10. You had talked about the different responsibilities of your job: educator, modeler of appropriate behavior and attitude, validator, developing different perspectives, developing the program, measuring outcomes, etc.
   a. How are you able to strike a balance between roles that seem so different?

11. As I had said earlier, you mentioned that you get discouraged. You had also mentioned that you get frustrated at times.
   a. Tell me about feelings of frustration as you have implemented the model.
   b. How did these feelings impact implementation?

12. You had talked about community attitudes toward the program and the clash of old world versus the new world sort of thinking and not feeling that you had the full support of the community.
   a. Overall, how does the model fit with the county?

13. In reference to fidelity items, you had stated that you think the whole penetration thing is ridiculous because it's not a true measure of what they're trying to measure.
   a. Tell me how you have been able to adhere to items on the fidelity scale
   b. Are there any items that you feel are problematic?

14. In the last interview, you stated that you like the fidelity review process because it's a constructive process with good feedback to assist you in developing the program.
   a. What type of practical knowledge or resources would assist you with your implementation process?

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