Researcher in Residence Program

Experiences from

New York State

Sponsored by:

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institutes of Health

Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration

In Cooperation with:

New York State Office of Alcoholism and Substance Abuse Services (OASAS)

Alcoholism and Substance Abuse Providers of New York State (ASAP)

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Executive Summary

The Researcher in Residence program has been a joint activity of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Center for Substance Abuse Treatment (CSAT), the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and the Alcoholism and Substance Abuse Providers of New York State (ASAP). The goal of the program was to encourage the adoption of research-based improvements in the treatment of alcoholism. NIAAA, CSAT, OASAS, and ASAP tried to accomplish this goal by inviting research scientists to make brief visits to alcoholism treatment clinics. During these visits, the scientists gave clinic directors and their staffs technical assistance on specific, research-based improvements in clinical practice. Clinic directors then made the organizational changes necessary to adopt these practice improvements as a routine part of their treatment regimen. The program was piloted at six sites in New York State during 2000.

This report on the program's results (adoption following the visits) is based on unstructured, followup interviews with the clinical directors and managers, counseling staff, and visiting scientists who participated. The principal conclusions emerging from this review are as follows:

1. A program of brief technical assistance visits stimulated adoption of research-based improvements in clinical practice at many of the participating sites.

2. Factors that contributed to adoption of research-based improvements included the resourcefulness of clinic directors, uninterrupted leadership from top level clinic management, communication skills of the visiting researchers, and personal experience of favorable outcomes on the part of counseling staff.

3. The principal barriers to adoption of research-based improvements were staff turnover, misperception that this project was a research study, and the burden of existing client information collections. Contrary to expectation, neither reimbursement problems nor existing treatment perspectives of the counseling staff prevented clinics from offering naltrexone therapy.

4. NIAAA and CSAT should continue to develop the Researcher in Residence program. The program could be enhanced by anticipating staff turnover, allowing sufficient time for interventions to take hold, and improving the match between intervention topics and clinical needs. Program flexibility should be maintained.

Introduction

The Researcher in Residence (RiR) program has been a joint activity of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Center for Substance Abuse Treatment (CSAT), the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and the Association of Substance Abuse Providers of New York State (ASAP). The goal of the program was to encourage the adoption of research-based advances in the treatment of alcoholism. NIAAA, CSAT, OASAS, and ASAP tried to accomplish this goal by inviting research scientists to make brief visits to alcoholism treatment clinics. During these visits, the scientists gave clinic directors and their staffs technical assistance on specific, research-based improvements in clinical practice. Clinic directors then made the organizational changes necessary to adopt these practice improvements as a routine part of their treatment regimen. The program was piloted at six sites in New York State during 2000. This report documents the results and the lessons learned from that effort. The key result reported is whether practice improvements were adopted following the researcher visits.

The program had some features that had not been demonstrated previously. No one knew whether researchers would be willing to participate in such an effort, whether providers would be able to adopt the proposed practice improvements, whether there would be sufficient common ground between researchers and providers to communicate effectively and to agree upon mutual goals, or whether clinical staff would follow the lead of clinic directors in implementing practice improvements. In effect, the program was a feasibility trial.

This report documents what was learned from the experience. It is a feasibility report rather than an evaluation study. It does not contain empirical measures of client outcome, assessments of intervention fidelity, comparisons against control cases, or other features of a traditional evaluation study. It simply presents a narrative account gathered from the researchers, treatment directors, and staff clinicians who participated in the program.

Background

An important challenge in the alcoholism treatment field is to reduce the traditional separation between those who provide treatment and those who conduct research (Brown 2000). As noted in the Institute of Medicine's recent report *Bridging the Gap Between Practice and Research. Forging Partnerships with Community-Based Drug and Alcohol Treatment*:

> Despite the great strides made in research on the etiology, course, mechanisms, and treatment of addiction, serious gaps of communication exist between the research community and community-based drug [and alcohol] treatment programs. Closing these gaps will not only be critical to improving drug and alcohol treatment, but will also be important to improving the nation's public health. (Lamb et al. 1998; p. 1)

This gap is disturbing to all parties involved in improving and delivering alcoholism treatment. For the Federal agencies, whose role has been, in part, to fund treatment research, it represents a frustration of one of our core purposes: to improve treatment by advancing the progress of scientific knowledge. Clearly a model that some might rely on, and that might work effectively in other areas of medicine, is not working for alcoholism treatment. This is the model in which publishing research advances in

scientific journals makes them available so that practitioners will notice them, learn how they might be applied, and adopt them. This is not happening (see Brown 2000) and leaves parties on both sides of the research-practice gap concerned about how to make research adoption work better.

The RiR project began with some preliminary insights about where we might start to improve the process. First, it seems that we need to go beyond mere publishing and the written word. There seems a need for direct, personal communication between researchers and providers, with hands-on instruction in new techniques. Second, it seems likely that the top level of clinic management is a key player in the process. Only focused effort by the clinic director can arrange the time and secure the resources needed for a practice improvement, change the organizational climate to accommodate a new technique, and effectively supervise the diffusion of new learning to front-line counselors. The RiR program was built around these two insights.

Both insights involve untried suppositions. Hence, it was necessary to document our experience as we proceeded. This report provides that documentation, with special concern for understanding the barriers that were encountered as research improvements were attempted. Better knowledge of these barriers would help adjust our efforts to be more successful in the future. Also, a candid accounting of the results of this project would help inform other parties who are similarly engaged in reducing the research to practice gap.

The RiR project was actually the second phase of a collaboration initiated by Jean Sommers Miller, Commissioner of the New York State OASAS, and Dr. Enoch Gordis, Director of NIAAA. They agreed that to implement changes in treatment practice, a first step would be to convene clinical supervisors and program directors from across New York and ask them to talk and work with researchers expert in alcoholism treatment. The resulting "Research to Practice Forum" was held in October 1998, with the additional and enthusiastic collaboration of CSAT and the Alcoholism and Substance Abuse Providers of New York State. The goal of the forum was to bring treatment providers and researchers together to discuss research advances and how these might be implemented in clinical practice.

As a "Phase II" of this effort, the RiR program aimed to arrange and support short visits by research scholars to treatment clinics, where they could provide technical consultation and thereby stimulate the adoption of improved clinical practices.

The four collaborating institutions (NIAAA, CSAT, OASAS, and ASAP) also hoped that personal contact between researchers and providers would give researchers fresh insights on the kinds of research most needed by clinicians. The gap between researchers and providers manifests itself in two, interconnected processes (Brown 2000; CSAT 2000; Lamb et al. 1998). The first is that providers have not made the best use of advances that the research community has provided. The second is that researchers have not provided research advances on several topics of critical interest to providers. Any advance in improving the conversation between researchers and providers inherently requires that progress be made in both directions. Although this particular exercise was focused primarily on the first "arm" of the problem (research to practice), real dialog between researchers and providers could not be built without also encouraging some progress in the practice-to-research arm as well. Although progress in this second area was a more indirect outcome of this project, both the participating scientists and the NIAAA and CSAT leadership reported an enhanced appreciation of the need to keep research focused on areas of clinical need and to enlarge provider input into the selection of research priorities.

Clinics interested in the concept invited researchers to make technical assistance visits by working through OASAS and the ASAP. Although many clinics were interested in extending an invitation and hosting a visiting researcher for a few days of intensive consultation, only a few could be selected for this experimental project. OASAS and ASAP made these selections. The criteria for selecting programs were demanding. They included past record of providing quality care, strong and innovative leadership, commitment to make a practice improvement, and willingness to expend the time and financial resources necessary to make such a change. In the end, the overall success of the project showed that these choices were well made.

NIAAA committed itself to selecting research advances that were "ripe" for clinical adoption (i.e., had strong scientific evidence of efficacy) and to selecting researchers who had both the scientific expertise and the clinical background that would be necessary. Each Researcher in Residence experience was to focus on implementing one specific, research-based improvement in clinical practice.

All parties involved (NIAAA, CSAT, OASAS, and ASAP) set modest, pragmatic goals for this feasibility test. The visits were to be brief; they would only begin to build the kind of ongoing personal engagement between researchers and providers that is needed. The program was not designed to provide resources to clinics, and in some cases this would be a barrier to adopting practice improvements. The program would affect only a handful of clinics in the State. Whether the results could be generalized more widely beyond these "pioneer" sites would remain an open question for future projects to address. Despite these limitations, NIAAA, CSAT, OASAS, and ASAP felt that a small program of technical consultation did have the potential to produce positive changes in clinical practice.

Project Activities

The NIAAA staff liaison made initial telephone contacts with participating clinics in August 1999. These calls served to make introductions and to solicit, from the programs, their selections of the target treatment improvements for each site. This approach had some shortcomings. Of the practice-improvement targets chosen by clinic directors, some were in areas where scientific evidence was not solid enough to guide a practice improvement. Furthermore, a significant research area that NIAAA wanted to make sure was included in the program, the adoption of pharmacotherapy in patient treatment, was not selected by any of the clinical sites.

Therefore, NIAAA and CSAT leadership asked for a meeting to rethink the selection of practice-improvement targets while at the same time ensuring that community provider needs were addressed. They also asked that the panel be expanded by the addition of two sites that would agree to make pharmacotherapy their practice-improvement target. OASAS and ASAP provided two additional candidates and a meeting was held on October 18, 1999, at the offices of Marc Galanter, M.D., Professor of Psychiatry and Director, Division of Alcoholism and Drug Abuse Services, New York University School of Medicine.

This experience in selecting target topics indicates that future versions of the Researcher in Residence program should start off by offering a restricted menu of interventions, covering areas where the science is known to be solid, for selection by the programs. The experience also indicated that this may be an opportune time to solicit input from clinicians on areas of need for increased research attention. For example, research on treatment for adolescents and research on treatment delivery systems designed for clients with mental health comorbidities were shown by this experience to be

areas of needed research progress. We learned that the match between provider needs and research accomplishments is not always a good one. Research findings might be available in areas where there is not a strong need for application among providers, or alternately there may be a strong provider need for research findings in areas where the science has not advanced sufficiently. In short, our experience confirmed the existence of the same gap between research and practice that animates this whole project.

Having made this adjustment, the six participating clinical sites selected the six target practice improvements shown in Table 1.

NIAAA staff then recruited scientists who had appropriate expertise in the six topic areas[1]. These researchers are also listed on Table 1. Two basic criteria were used in the selection of researchers. They needed to have nationally recognized expertise in the relevant topic area, and they also had to be familiar with applied treatment settings. Also, of course, participating researchers needed to be able to commit the time necessary for the project. NIAAA feels fortunate that many of the field's most prominent researchers agreed to participate in the project.

Once researchers had been recruited, a meeting was held to bring together clinic directors, researchers, and staff from NIAAA, CSAT, OASAS, and ASAP. The meeting was held December 1, 1999, at NIAAA's offices in Rockville, Maryland. The meeting introduced clinic directors and researchers to each other, identified the specific objectives to be accomplished by each residency visit, scheduled a date for each visit, and began planning the activities that would occur during the visits.

Clinic directors and researchers worked in pairs and had considerable flexibility to design a visit that would best meet their mutual needs. One example of this flexibility was the number and sequencing of planned residency visits. The project budget allowed for two visits, originally conceived as a 2-day initial visit to deliver the intervention followed a few weeks later by a 1-day visit to reinforce the original message and address problems that might have arisen during implementation. However, wide latitude was used. Some initial visits were less than 2 days, reflecting the participating parties' determination that less time would actually be needed for some interventions. Some teams held two visits while others felt the business could be accomplished in one visit. Some teams reversed the order of the longer and the shorter visit, using the shorter one to familiarize the researcher with the operations of the clinic (i.e., a "reconnaissance" visit). This would aid in appropriately designing the intervention delivered during the longer visit to follow.

The researcher visits were held between January and April 2000, each scheduled at a time of mutual convenience to the visiting researcher and the hosting clinic. In most cases a 2-day visit was planned, although some of the visits lasted 3 days and some 1 day. In two cases, a "reconnaissance" visit preceded the main visit. In one case, a booster visit followed the main visit.

After each visit was held, the NIAAA project liaison held a telephone debriefing with the visiting researcher to discuss the course of the visit. This debriefing covered the instructional presentations given, the books, videotapes, and other materials used, the role-playing exercises conducted, and so forth. Initial reactions of program staff to the presentation were also discussed.

[1] Although the original intention was to recruit six scientists, one for each site, one of the recruited scientists, Dr. John Allen, had expertise in two of the selected topics. Therefore, he served as the visiting researcher at two sites.

Table 1. Researcher in Residence Sites

Clinical Site	Lead Participating Provider	Visiting Researcher	Intervention Topic
Amsterdam, NY St. Mary's Hospital Alcoholism Services	Sherrie Gillette, M.A., C.A.S.A.C. Director of Addiction Services	Stephanie O' Malley, Ph.D. Department of Psychiatry Yale University School of Medicine	Administration of Naltrexone
Buffalo, NY Margaret A. Stutzman Addiction Treatment Center	Steven Schwartz, Ph.D. cand. Executive Director	Alan Zweben, D.S.W. School of Social Welfare University of Wisconsin, Milwaukee	Client Motivation and Retention
Commack, NY Catholic Charities of the Diocese of Rockville Centre	Kathleen Ayers-Lanzillotta, M.P.A., C.A.S.A.C., Program Administrator, Chemical Dependency Services	Helen Pettinati, Ph.D. University of Pennsylvania Alcoholism Treatment Research Center	Improving Services for Clients with Mental Health Comorbidities
Guilderland, NY St. Peter's Addiction Recovery Center	Walter Alston, M.S.W. Program Specialist	John P. Allen, Ph.D., M.P.A. Division of Clinical and Prevention Research, NIAAA	Assessment and Client Feedback
Manhattan, NY Bellevue Hospital Outpatient Alcoholism Treatment Clinic	Andrew Weintraub, Ph.D. Chief Addiction Psychologist	Bankole Johnson, M.D., Ph.D. Department of Psychiatry, University of Texas Health Science Center	Administration of Naltrexone
Queens, NY Outreach Project	Kevin Wadalvage, M.A. Vice President	John P. Allen, Ph.D., M.P.A. Division of Clinical and Prevention Research, NIAAA	Assessment and Client Feedback among Adolescents

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The original plan called for a 3-month period after the researcher visit for the intervention to take hold. Then a followup visit was to be made by the NIAAA project liaison to assess the results of the project. However, many clinics did not feel ready to report on progress at 3 months, feeling that extra time was needed for the intervention to be given a fair chance. Thus, followup visits were delayed. The last ones were not held until late August 2000.

At the followup visits, the NIAAA project liaison was accompanied by a member of the OASAS staff. The pair held interviews, typically lasting about 4 hours with all of the provider staff who were involved with the intervention. Typically this began with a long interview with the clinic director[3].

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[3] This report uses "clinic director" as a generic term for the member of the provider staff who took the lead role in the project at each site (see Table 1). The term is not strictly accurate since some of these lead persons had official titles other than

Individual interviews were then held with other senior administrative staff (including hospital administrators, staff psychiatrists, and physicians). Then interviews were held with front-line counselors who were involved in the project. Sometimes the interviews with counselors were conducted individually and sometimes in groups, according to the convenience of the clinic. All interviews were recorded. The information gathered during these followup interviews forms the basis of the reports below. Each case study follows the same format. Each begins with a description of the clinical site, a statement of the intervention attempted, and the clinic's rationale for selecting that intervention. Next, the researcher visit is described. Then, the result of the attempt to change clinical practice is assessed. Factors that contributed to adoption of a practice improvement and barriers to adoption are then discussed. Finally, recommendations for improving the program are suggested. Following these case studies a closing section discusses conclusions that emerged across more than one case.

Case Studies

Amsterdam, NY; St. Mary's Hospital Alcoholism Services

St. Mary's Hospital is the main provider of alcoholism services in a predominantly rural county. As such, it provides a range of services that include a 24-hour crisis telephone line, inpatient medical detoxification, an inpatient rehabilitation unit, two outpatient (day hospital) programs, and an outpatient clinic.

The target intervention at St. Mary's was the administration of naltrexone to patients in inpatient care. Naltrexone would not have been selected by the clinic as its first choice of interventions,[4] but it was accepted at NIAAA's suggestion as a condition of participation in the project.

St. Mary's decided to conduct this trial among its inpatients for several reasons. First, the staff determined that the cost of the drug was reimbursable under the State's fee-for-service Medicaid program. All inpatients at St. Mary's are covered by fee-for-service Medicaid. Second, patient histories, physicals, and lab tests of liver function were already being administered for all inpatient admissions, and hence, no additional costs would be incurred in taking these necessary preliminary steps. Patients could be oriented to the medication through an instructional module placed in the existing curriculum. Finally, medication compliance and tolerance could be monitored effectively in a structured program. Staff began with the hope that successful experience with the inpatient program would lead to the introduction of naltrexone in St. Mary's outpatient clinic at some later time.

The visiting researcher, Dr. Stephanie O'Malley (who was accompanied by her associate Dr. Boris Meandzija), visited St. Mary's Hospital on February 8 and 9, 2000. The visit began with informal presentations of the project to hospital management, administrators, and prescribing physicians. More formal didactic presentations were given to the inpatient and outpatient counseling staffs. Finally, the researchers and clinic director had a private meeting to develop the implementation plan and to discuss quality improvement indicators that might be applied to monitor the results of the project.

In addition to information on research findings about naltrexone's effects, the formal presentations included administration techniques, contraindications, side effects, administration and interpretation of a

director.

[4] The clinic would have selected assessment tools or treatment for mental-health comorbidities instead if given the choice.

craving scale, use of a patient "urge to drink" diary, and dissemination of CSAT's Treatment Improvement Protocol manual *Naltrexone and Alcoholism Treatment* (O'Malley 1998).

An innovation created by the clinic director unique to this RiR trial was to call press attention to the researchers' visit. This resulted in favorable coverage in Amsterdam's *Recorder* (Lindsley 2000) and Schenectady's *Daily Gazette* (Fox 2000). These reports helped boost the success of the program in several ways. They created a favorable impression with hospital management by highlighting the hospital as a center of innovation; they energized the counseling staff to support what was seen as an important project; and they triggered many calls from potential clients interested in trying the new pharmacotherapy. In fact, the reaction was so strong that the outpatient counseling staff felt that they had to respond by making naltrexone available in the outpatient clinic as well, thereby jumping the gun on the original plan to test the implementation among inpatients first and expand it to outpatients later. By expanding to the outpatient clients, the naltrexone administration exercise actually exceeded the level of success that had originally been hoped for.

The first of two key barriers that would have to be overcome in the course of this project was reimbursement for the cost of the medication. The clinical director, with help from the OASAS office, spent considerable time to determine that costs for naltrexone could be reimbursed for patients who participated in the fee-for-services side of the State's Medicaid program. Since all inpatient clients at St. Mary's were covered by fee-for-service Medicaid, this resolved a significant potential financial barrier to the program. The simple knowledge that this barrier can be overcome may be one of the most significant practical achievements of the RiR program in New York State.

Clinic staff are currently working on determining whether the larger managed care plans participating in the State's Medicaid managed care program also reimburse naltrexone, which will clear the way for expansion of the intervention into St. Mary's outpatient program. Since any clinic in the State would have to make these inquiries before establishing a naltrexone administration program, OASAS should consider making a centralized investigation of this issue among the larger managed care plans operating in the State and publishing the results in a handbook that could be used by the State's providers.

The second barrier to implementation was resolved prior to the researcher visit, but was almost fatal to the project. In the beginning, there was a misperception, among hospital management and physicians, of NIAAA's purposes in the RiR program. Rather than being seen as the feasibility trial that it was, the program was seen as a clinical trial. Therefore, senior staff anticipated that there would be a considerable burden of outcome measurement and patient followup for which no resources were being provided. Consequently, there was strong opposition to participation in the program. This opposition was only overcome by repeated explanations of the project's true intent and determination to proceed by the clinic director.

By contrast, a barrier that NIAAA staff initially expected to emerge, ideological opposition to offering medications as a part of an abstinence oriented and 12-step based therapy, did not seem to cause much interference. None of the counseling staff interviewed felt this was a problem or that naltrexone was incompatible with their therapeutic approach. The clinic director and chief

physician reported that because the clients at St. Mary's are frequently treated for mental health conditions and because staff routinely use medications in this treatment, the introduction of medications to treat alcoholism had familiar precedents.

A key factor facilitating adoption was the communication skill of the visiting researcher. Her ability to tailor her message appropriately to different audiences and her strong interpersonal skills were rated as invaluable in the followup interviews. She was especially persuasive in winning over the principal staff physician, whose position as the main prescriber of any medications administered made him a critical participant in the intervention.

Also important, at the key moment when senior management were verging on non-cooperation with the program because of concern about the resource burden that would accompany the project, was the prestige of working with the two Federal agencies, with OASAS and ASAP, and with researchers from Yale University.

Once prescriptions began to be issued, personal experience with improved outcomes among the clients cemented support among the counseling staff. Though open-minded and willing to try the intervention following the researcher's presentation, staff maintained an attitude of cautious skepticism about its ultimate value. However, after improved outcomes were achieved with some treatment-resistant cases and anecdotes about these cases circulated among the staff, support became wholehearted. This is an important observation for readers trained in the research tradition to recognize. Scientific evidence and journal publications may not necessarily or fundamentally secure belief of efficacy among front-line alcoholism treatment counselors[5]. These counselors are ultimately persuaded by personal experience of improvement in individual clients under their care. A technology transfer exercise would be well advised to build in a chance for this to happen.

The relative ease of prescribing the medication helped the program accomplish its objectives. The inpatient clinic offered an environment where orientation, administration, and monitoring could effectively occur. Finally, the unit had few experiences with negative side effects of the medication.

In sum, the goal of introducing naltrexone administration among inpatients at St. Mary's Hospital was clearly met. As of the followup site visit, some 53 patients had been placed on the medication and there was little reason to think that staff might discontinue use.

One important barrier remains to expansion of the program into the outpatient clinic. Counselors there have gotten the impression that naltrexone is to be selectively prescribed only to those patients who report high levels of craving. This misunderstanding might be traced to instruction that was given on the use of a craving scale. The clinic director is trying to reeducate the outpatient staff on this point.

A possible improvement for the RiR program was suggested by the clinic director and the visiting researcher. Both suggested that it might be valuable to have funds available for a small-scale evaluation study of program effects. Such a study could be important for three reasons. It could help convince hospital management of the value of the intervention. It could serve as a means of demonstrating effects to program staff. Finally, it would provide some objective evidence that the clinic has been engaged in improving the quality of treatment, which rewards innovative clinic directors for their efforts before such important audiences as hospital administrators, state administrators, and quality assurance monitoring boards. We note, however, that although these benefits have considerable merit, they are a step toward

[5] A similar point is made in Brown's (2000) recent analysis of the research to practice gap.

the "clinical trial" model that caused so much confusion about the purpose of this exercise. The issue needs, and deserves, careful consideration.

Buffalo, NY; Margaret A. Stutzman Addiction Treatment Center

The Margaret A. Stutzman Addiction Treatment Center is a 33-bed, inpatient residential rehabilitation facility that is medically supervised and staffed by a multidisciplinary treatment team. The length of treatment varies from three to four weeks, depending on client need. After discharge, clients are referred to an outpatient program, sometimes into a halfway house. Stutzman is a state-operated facility. Services are made available to persons who reside in a five-county area in western New York.

The clinic was interested in motivational enhancement as a way to improve client retention rates. Retention rates are important to Stutzman because the clinic is regularly evaluated on this index by both its state funding agency (OASAS) and by accreditation boards, notably the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Stutzman was concerned that its retention rate, in the 60 to 70 percent range, was slightly below average for other inpatient facilities in the state.

Dr. Allen Zweben visited the clinic February 22–24, 2000. His presentation included didactic sessions, role-playing exercises, and use of the CSAT manual *Enhancing Motivation for Change in Substance Abuse Treatment* (Miller 1999). Drs. Paul Stasiewicz and Gerard Conners from the nearby Research Institute on Addictions also gave a presentation entitled "How to engage and monitor clients in alcoholism treatment: Recent findings."

Stutzman's clients are a somewhat difficult population to reach with motivational techniques. They are referred to Stutzman from outpatient clinics because they lack enough structure in their lives to make use of an outpatient program. Stutzman tries to provide this during a 3- to 4-week residential stay and then refers clients back to the outpatient clinics that originally sent them. Also, because it must establish rules for group living in an institutional setting (assignments for cleaning the bathrooms and kitchen, schedules for sleeping and meal times, prohibitions on sex between clients, etc.), it tends to employ (and must ultimately rely on) a directive, potentially confrontational style of client management. How to accommodate both a directive and a motivational approach to clients in an inpatient setting was a significant challenge.

It is important to note that Stutzman's director went beyond the level of individual counseling behavior in his application of the motivational enhancement approach. He also tried to change organizational practices that seemed incompatible with the theme of engaging and enhancing client motivation. For example, public address announcements such as "Joe R., report to the nursing station. You forgot to take your medication." were felt to be inconsistent with the self-efficacy that motivational enhancement tries to build and were changed accordingly.

The director thought that hosting the researcher's visit the week after Stutzman had gone through a site review by JCAHO would be a "treat" and a change of pace for the staff, but this plan did not turn out well. Exhausted by their extensive preparations for the JCAHO review, the staff were too drained to absorb the training effectively.

Timing also worked against Stutzman in that there was extensive staff turnover following the researcher visit. Five members of the counseling staff unexpectedly left Stutzman shortly after the visit. Understandably, these departures drained energy and meant that remaining staff had to cover the duties of departed staff. This impaired the focus needed to implement a practice improvement.

Assessing the situation in April, the director determined that motivational enhancement was not being implemented appropriately. He therefore undertook a series of steps designed to rejuvenate the effort. These included ordering another set of TIP manuals for the new replacement staff, ordering Miller and Rollnick's videotape (1998) on motivational interviewing, reviewing the main points of the technique with all staff, and emphasizing the approach at staff meetings and through intra-office communications. The combined effects of staff turnover and the campaign to reinvigorate the intervention delayed the project. Followup interviews were not held until August 23, 2000.

Results showed substantial adoption of a practice improvement, although this might be of uncertain permanence. Followup interviews with the counselors showed that they divided into three roughly equal-sized groups. For some counselors, motivational enhancement training resonated with their natural style of counseling. They were heartened to hear that there was scientific evidence to back the style that came naturally to them and were thereby encouraged to stick with it. Notably, the counselor who handled a special Native American program felt that the motivational enhancement approach was particularly well suited to working with this cultural group. Other counselors could be called converts. They began the project with open minds, gave the motivational approach a try, and found that it produced good results. As at other sites, personal experiences of success were remembered and reported as evidence that the approach had merit and that the counselors intended to continue using it. For still other counselors, however, the motivational approach did not come easily. These had to make an effort to employ it and were probably uneven in their application. To some extent, these counselors reported giving lip service to a treatment approach that was obviously being encouraged by their supervisors. However, even those most skeptical of the approach reported that it was useful for some situations and that they believe themselves better off to have included it in the mix of approaches in their therapeutic "toolbox."

From the director's perspective, the results of the experiment to adopt motivational enhancement techniques are not yet known. Completion rates are still fluctuating in the 60 to 70 percent range. Although the motivational techniques have been adopted in staff practice, the director reports that it is too early to tell whether they have achieved the desired effect on completion rates[6]. Thus, the long-term future of Stutzman's experiment with motivational enhancement was still uncertain at the time of the followup interview.

It also should be noted that in this intervention, there seemed a strong need to apply periodic booster sessions to the original training. In fact, the NIAAA staff liaison's followup visit was molded into such an occasion.

Factors contributing to the adoption of practice improvement begin with the effectiveness of the researcher, who was seen as an effective communicator. Previous staff experience with innovative techniques was also a plus. The staff had experience in being one of the first facilities to adopt a tobacco-free treatment environment and to establish a program for Native Americans. Finally, the director showed great resourcefulness in this experiment, reinvigorating the change process when it appeared stalled, locating additional training resources to help newly hired staff, responding to unexpected staff turnover, and recognizing that change is best facilitated at both the individual and the organizational levels.

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[6] Interpretation of the effects is confounded by an initial improvement in retention rates that occurred shortly before the researcher's visit. This improvement is felt to be due to a newly instituted program of conducting daily rounds.

The greatest barrier to adopting a practice improvement was in the timing of the intervention. This is true both because the original training occurred when staff were exhausted from their JCAHO review and because unforeseen staff turnover posed a significant problem here, as it did at other sites.

A second barrier would appear to be the inherently greater difficulty of an intervention that calls for changing established counseling styles. This intervention appears to be more difficult than some of the others attempted in the RiR program because it requires more change in existing counselor behavior.

One recommendation for the future is to not overinflate the expected results. Change is difficult to accomplish and takes time.

The other principal recommendation is to anticipate staff turnover problems. Though specific staff departures can't be foreseen in advance, we know that turnover is high among alcoholism counselors, and we should plan with this in mind. Directors should be asked to assess the likelihood of staff disruptions right before the researcher visit (which can be postponed). Videos of the researcher's presentation and auxiliary instructional materials should be collected to instruct replacement staff. Also, innovators or early adopters among the staff could be identified as persons who could train replacement staff.

Commack, NY; Catholic Charities of the Diocese of Rockville Centre

Catholic Charities of the Diocese of Rockville Centre provides social services in two ways: (1) it provides services directly by operating clinics such as its alcoholism treatment clinics, which are funded by OASAS; and (2) it provides services indirectly through a network of 134 parish outreach programs, where persons are helped by parish-based staff and volunteers. Several kinds of human services are provided, including both alcoholism treatment services and mental health services. Catholic Charities operates Talbot House (an inpatient chemical dependency crisis center), Commack Alcohol Day Treatment and Clinic Services (the site of the RiR intervention), Hampton Bays Alcohol Clinic (an outpatient clinic in a rural area of Long Island), several outpatient mental health clinics, a residential psychiatric facility for adults, and a residential psychiatric facility for children.

Because both alcoholism treatment and mental health services are provided by Catholic Charities and because increasing numbers of clients were presenting with combined mental health and substance abuse disorders, Catholic Charities had become interested in improving its services for individuals who suffer from both conditions. Hence they formed a MICA (mentally ill chemical abuser) committee to explore better ways of coordinating service delivery, potentially leading to the development of new services within Catholic Charities that would be designed to address both disorders simultaneously.

Given this interest it was natural that the agency chose "Designing Programs for Clients with Mental Health Co-Morbidities" as its intervention topic. However, at the December 1999 Planning Meeting, it became apparent during discussions between the clinic director and the visiting researcher that research could not supply all the answers that the clinic needed on this broad goal. Therefore, it was decided to focus the RiR exercise on a specific, more limited piece of the whole where research could offer solid guidance. The narrower goal selected for the RiR visit was to implement screening for depression among alcoholism patients. This would enable the clinic to connect those clients to mental health services more rapidly. However, the agency

also took advantage of the researcher's general expertise to explore additional questions related to the broader goal of coordinating services during the visit. In short, a full appreciation of what transpired at Catholic Charities needs to keep in mind that both a narrow and a broad goal were pursued.

The visiting researcher, Dr. Helen Pettinati, made two visits to the site, one on February 14, 2000, and one on April 12, 2000. The first visit centered on two informational presentations. One, given at an agencywide meeting of psychiatrists and administrators, covered research on pharmacotherapy, principles of addiction treatment, and barriers to improving treatment. It was designed to address the broader rather than the narrower goal of the project. The second presentation was given to a smaller group of counselors at the outpatient Commack Alcohol Day Treatment and Clinic Services unit. It focused on the use of the Beck Depression Inventory (BDI; Beck et al. 1961) and the Symptom Check List 90 (Derogatis et al. 1974) as instruments to assess mental health comorbidities. Discussion among the staff concluded that the Beck Depression Inventory would be the preferable instrument to adopt, and staff began administering it on a trial basis to 25 clients. The results were sent to the researcher for scoring. At the second visit, the researcher reviewed the results of these sample cases in order to teach staff about scoring, interpretation, and decision making. Working through these specific examples with the researcher was felt to be quite helpful by the staff.

Later, on June 7, 2000, the director of Catholic Charities made what might be called a "reverse" residency visit to two Philadelphia area clinics that were familiar to the researcher. These clinics served as working examples of clinics offering integrated mental health and substance abuse treatment. This gave the Commack director an opportunity for concrete discussion of specific problems that arise in joint service delivery.

Use of the Beck Depression Inventory was implemented as planned in the Commack Alcohol Day Treatment and Clinic Services unit[7]. Administration was centralized in a single counselor, who reported that he found the Beck to be simple to administer and that the information it provided was distinctly useful in making clinical decisions. The time and resource costs of the Inventory were minimal, so there was little reaction that the instrument was "yet another unnecessary assessment" that had to be administered. In other words, the "buy in" by the counseling staff was secured. There is every expectation that the change in practice that was implemented will be durable.

The broader project of increasing coordination between Catholic Charities' mental health and alcoholism services is still a work in progress. The MICA committee continues to meet and the agency continues to feel its way toward the development of a joint substance abuse and mental health program.

In sum, the smaller purpose of implementing depression screening was accomplished as planned and appears to be on a secure footing. The broader purpose of assisting the coordination of alcoholism and mental health services was given some positive momentum by participation in the RiR program, but this benefit was small in comparison to the overall task facing the agency.

When asked about factors that helped facilitate adoption, administrative and counseling staff uniformly and immediately replied that the ability of the researcher to communicate effectively with the staff was a key attribute. The researcher was seen as excellent at "speaking the counselors' language"

[7] Although thought was also given to implementing depression screening at Talbot House, an inpatient and detox unit, staff felt that the largely homeless, crisis clients typically seen there were too unstable for useful assessment until they had passed along into an outpatient program.

and she demonstrated clear familiarity with the day-to-day problems of a counselor's work. These effective communication skills would appear to be essential factors in facilitating adoption.

Another factor that facilitated adoption was the ease of implementing the Beck Depression Inventory. Because a small, easily manageable intervention requiring few outside resources was attempted, there were few barriers to adoption. The perceived utility of information from the screening was great enough to make any small costs encountered seem acceptable.

Finally, the "reverse" residency visit to Philadelphia was cited as a very valuable experience by the Commack director. Future versions of the RiR program should consider making this option available.

On the negative side, some factors reduced enthusiasm for the program. Chief among these was that research had not made enough progress in the overall area of designing optimal programs for combined mental health and substance abuse services. Thus research could not offer as much concrete advice as the program would have liked. This underscores the continuing need for more research progress on some of the practical issues faced by clinicians.

Another negative was that the program must, perforce, come to an end. All participants knew that RiR was designed as a short and limited exercise in technology transfer, but precisely because the clinic director found the effort to be so useful, there was concern about keeping personal contacts open to the research community so that advice on future issues could be sought. NIAAA, CSAT, OASAS, and ASAP should think constructively about what they can do to keep these channels open.

Guilderland, NY; St. Peter's Addiction Recovery Center

St. Peter's Addiction Recovery Center (SPARC) provides a comprehensive set of alcoholism treatment services, including inpatient and ambulatory detoxification, inpatient rehabilitation, a halfway house for men, outpatient treatment, dual diagnosis programs for combined drug and alcohol abuse, and drinking driver programs. The intervention chosen was the use of standardized assessment instruments and giving client feedback based on those assessments. The original plan was to introduce this intervention in both residential and outpatient programs. However, implementation only occurred at an off-site, outpatient clinic in Cohoes, New York.

SPARC was interested in assessment because it had already decided to overhaul its intake process. This meant that SPARC was reviewing all of its procedures for getting client information, including information required by OASAS reporting requirements and information required for JCAHO accreditation.

The visiting researcher, Dr. John Allen, decided to reverse the usual schedule of visits and make a short "reconnaissance" visit to familiarize himself with the clinic and its operations before making the main visit to deliver technical assistance. The reconnaissance visit was conducted on January 5, 2000, and the main visit was conducted on March 1–3, 2000.

During the main visit, instruction was given on the administration of five instruments: the Drinker Inventory of Consequences (DrInC; Miller et al. 1995), the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller and Tonigan 1996), the Alcohol Abstinence Self-Efficacy Scale (AASE; DiClemente et al. 1994), the Negative Alcohol Expectancies Questionnaire (NAEQ; McMahon and Jones 1993a and b), and the Alcoholics Anonymous Affiliation Scale (AAAS; Humphreys et al. 1998). Instruction also included giving feedback based on assessment results. Use was made of a "Personal Feedback Chart" for giving this feedback. Prochaska and DiClemente's (1992) stages of change model was explained. An instructional videotape prepared by Stephen

Rollnick and William Miller (1998) was viewed, and a role-playing exercise reinforced the message of these instructions. The visiting researcher also presented general information on the proper rapport and environment for administering instruments and on using the assessment results to develop a treatment plan.

During these presentations staff raised several concerns about many of the "nuts and bolts" issues such as when the instruments would be administered, by whom, where in the clinic this would be done, and how the new assessments would be meshed with the existing burden of information collection already required by OASAS and JCAHO. It is important for researchers to understand how important these practical concerns are to practicing clinicians. It should be clear that one potential barrier to any assessment-based intervention is this burden of existing requirements.

Plans were soon overtaken by events. After the researcher's visit, the director of SPARC, who had been with the agency for 15 years, resigned. Given that this director had guided the clinic for so many years, SPARC became subject to a considerable amount of organizational turbulence. The director's responsibilities were assumed by subordinate staff, a new director was recruited, and uncertainties about whether to continue or revise initiatives begun by the outgoing director were settled.

At the same time, SPARC absorbed another previously independent treatment center. Whereas SPARC was operated on a not-for-profit basis, the newly absorbed center had operated on a for-profit basis. Reconciling several issues related to this difference further preoccupied management attention.

Taken together, these developments detracted from the focus of attention and commitment that were required for making a significant change in clinical practice.

Another factor that limited the prospect of adoption was the communication style of the visiting researcher. Some line staff reported that the presentations were too abstract or too academic to be fully effective. In fairness, staff credited the researcher's ability to rephrase and respond to their questions, and the same researcher communicated effectively when presenting similar material at another site (Outreach Project). Without blaming individuals, the lesson to be taken from the experience is, again, that effective communication style was a very important ingredient of the outcome of this program.

After the researcher departed, SPARC had to make a number of decisions. Staff were divided between some who were enthusiastic and others who wanted to withdraw from the RiR program. SPARC had to decide whether to go ahead with the project, given other distractions. The interim director reported that staff advocacy for the project and the prestige of working with OASAS, ASAP, CSAT, and NIAAA were important factors in the decision to proceed. Decisions also had to be made about which instruments to adopt and which units within SPARC would participate. These decisions were resolved within a philosophy of maximizing "ownership" of the intervention by front-line clinical staff. Implementation would move ahead only to the extent that counselors wanted the new approach and saw benefit in its application.

In the end, it was decided that assessment and feedback would be tried at the Cohoes outpatient unit, where staff support for the intervention was strongest. The results would be monitored, and based on that evaluation a decision would be made whether to expand their use in other units. That evaluation was still pending at the time of the followup visit.

The Cohoes counselors reported using the Alcohol Abstinence Self-Efficacy (AASE) and the Alcoholics Anonymous Affiliation Scale (AAAS). Both instruments were found to be useful when incorporated into group therapy sessions. They were helpful tools in raising client self-reflection in a

nonjudgmental way and in helping patients to understand and monitor their progress in recovery. Counselors reported the intention to continue using both tools in the future. Less use was made of the Drinker Inventory of Consequences (DrInC) or the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). Staff also reported that scoring the instruments was a struggle. Assessment interventions need to keep in mind that counselor unfamiliarity with scoring protocols can be a barrier to adoption.

The overall assessment of this residence experience is one of mixed outcomes, temporarily secured. Important progress was made in the use of some standardized assessment tools and using those results to guide group therapy discussions. However, not all of the instruments discussed by the researcher were adopted, adoption was limited to one unit within the SPARC system, and feedback based on the instruments was given in group rather than individual sessions. Whether these changes will take hold permanently is still unknown. While counselors who use them are supportive of wider adoption within SPARC, the management evaluation of this exercise is still pending.

Lessons learned from the experience at SPARC would seem to include the following. Sustained focus of attention by clinic management is essential for the adoption of a clinical improvement. Uncontrollable events, like personnel changes in a field where turnover is high, can easily disrupt the focus. Communication style of the visiting researcher plays a large role in the results.

Manhattan, NY; Bellevue Hospital Outpatient Alcoholism Treatment Clinic

The Division of Alcoholism and Drug Abuse at Bellevue Hospital operates six programs for alcoholism and substance abuse. An Outpatient Alcoholism Treatment Clinic was the site for the Researcher in Residence project. This clinic primarily treats clients who are homeless or living in shelters. Rates of drug abuse and mental health disorders are high in this population. The clinic offers a diverse menu of daytime treatment services, among which the clients chose. The clinic is crowded and has limited funding, with only one physician available for 60 to 70 patients seen each day.

Other programs operated by Bellevue are as follows. A 27-bed Dual Diagnosis Unit treats combined psychiatric and addictive disorders. A 30-bed Alcohol Inpatient Unit provides both short-term detoxification and long-term inpatient rehabilitation. A Methadone Maintenance Treatment Program provides care for opiate abusers. An ambulatory treatment Recovery Program is provided for cocaine abusers. A Continuing Treatment Program provides a halfway house for dually diagnosed mental health and substance abuse patients.

The Outpatient Clinic had some prior experience with naltrexone, but the medication had not been used extensively. Staff hoped to get a greater familiarity with its use. However, naltrexone administration was an intervention required of the clinic as a condition of participation in the Researcher in Residence program. In the followup interviews, senior staff depicted pharmacotherapy as somewhat less relevant to the needs of a multiproblem, homeless population and as a treatment improvement falling farther down the list of the clinic's immediate priorities.

Dr. Bankole Johnson, along with his colleague Dr. Nassima Ait-Daoud, visited Bellevue February 8–9, 2000. This visit concentrated on discussions with senior staff about how to design a system for administering naltrexone and for evaluating its effects on client outcomes. In working through this problem, the researchers and senior clinical staff were unable to arrive at a project design that did not require a research assistant to administer assessment instruments, monitor compliance, and collect outcome data. They called the NIAAA project liaison to request funds for such an assistant (there

being none available within Bellevue), but there was no project budget for such assistance. Furthermore, this request would have changed the overall design of the Researcher in Residence project from an investigation of whether a small dose of technical consultation alone could be useful in effecting practice improvement to one in which consultation plus accompanying resources would secure such effects.

With the clinic unable to move forward without added resources and NIAAA unable to provide those resources, the project came to an impasse. On April 25, 2000, a conference call was held to determine whether the program should be terminated at the Bellevue site. During the call, however, it was announced that a psychology extern[8] at Bellevue had volunteered his services to put a naltrexone intervention into place.

By June, a naltrexone therapy option was placed on the menu of therapeutic choices. Bellevue counselors were to advise clients of the availability of this option and refer those who were interested. The extern would administer a brief screen, arrange for a supply of medication, monitor its distribution (working with the nursing staff), monitor potential side effects, and conduct 30-day and 3-month followup interviews on patient outcomes.

Note that this plan made naltrexone available as an option, but the adoption of the target improvement depended on whether patients would actually select that option. In fact, no patients ever selected the naltrexone option. Thus, not a single dose of naltrexone was administered as a result of this project.

At the followup interview, several reasons were given for the patients' disinclination to chose the naltrexone option. The drug was unfamiliar and had no reputation on the street as something that might be helpful in alcoholism recovery. There was concern about interactions with other medications, which are frequently taken by this population. Embarking on a course of naltrexone involved making more of a commitment to treatment than many patients were willing to face up to.

The encouragement for patients to select this option was not strong enough. Staff had not been given training in naltrexone's use and potential benefits. This lack of "in-service training," left staff ill-prepared to promote the option.

It is worth noting that a few positive lessons emerged. First, there was not, as expected, a financial barrier to offering naltrexone. Bellevue staff determined that Medicaid would reimburse the cost of the drug[9]. Second, there were no ideological reservations expressed. Staff did not voice the opinion that pharmacotherapy was an unacceptable avenue toward sobriety.

Two barriers to adoption at Bellevue merit discussion. First, this project suffered to the extent that its purpose was conceived to be or construed to be an opportunity for gathering data and assessing outcomes. This misperception contributed toward the felt need for a research assistant, and when resources were not available to hire such an assistant, the project stalled. Second, the planning for the intervention had some shortcomings. First, the full set of activities that would constitute the intervention had not been planned in advance of the research visit. Second, the planning did not include in-service training for the clinical staff. This left staff in a weak position to encourage patients to select the option.

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[8] NIAAA, CSAT, OASAS, and ASAP would like to express their appreciation to David Roos, Queens, New York, for volunteering to help the project at this critical juncture.

[9] Note, however, that in this population it is often difficult to get patients through the system that qualifies them to receive Medicaid benefits.

Third, plans left the initiative and leadership of the intervention in the hands of too junior a person within the organizational structure.

Four recommendations to guide future RiR programs emerge from this experience. The selection process whereby clinics are matched to topics needs to be improved so that interventions delivered are those that meet the higher priority needs of the participating clinics. There should be greater clarification that the project is a technology transfer exercise rather than an outcomes study. There should be more careful monitoring by NIAAA staff of the pre-visit planning. Finally, interventions need be targeted at securing "buy in" and participation by the front-line counseling staff.

Queens, NY; Outreach Project

Outreach Project was founded in 1980 to provide assistance to individuals with alcoholism and drug abuse. Starting as a provider of assessment and referral services, Outreach found many gaps in services for this population. It has responded, over the years, by designing services to fill these needs. In 1983, Outreach began providing court advocacy services for the adolescent population[10]. At the same time, they founded Career Assessment and Development Services to provide vocational services to adolescent drug abusers. Outreach provides residential services for adolescents at two Outreach House locations. In 1994, Outreach began providing outpatient adolescent services through their Family Services Program. Their Alternatives Program opened in 1995 to provide outpatient substance abuse counseling to individuals placed on probation. Residential therapeutic communities for youth are also operated by Outreach (opened in 1984 and 1991). In April 1998, Outreach began an adolescent day program for substance-involved youth aged 13 through 18. This program provides onsite schooling as well as treatment; however, clients return to their homes in the evening. The program serves an adolescent population with multiple problems: alcohol abuse, substance abuse, truancy, unstable home environments, and criminal justice offenses. The RiR project was conducted in this adolescent program.

Outreach was interested in administering assessment instruments to adolescents and providing client feedback based on those assessments. The topic was something of a compromise between the clinic's principal need, improving treatment services for adolescents, and the Institute's judgment that there was insufficient scientific evidence to guide a practice improvement in treating adolescents except for evidence on the assessment of adolescents.[11] The visiting researcher, Dr. John Allen of NIAAA's Division of Clinical and Prevention Research, elected to make a "reconnaissance" visit on December 21, 2000, prior to making his main visit March 8–10, 2000.

The content of the main visit was much the same as that presented at SPARC. Instruction was given in the administration of five instruments (DrInC, SOCRATES, AASE, NAEQ, and AAAS). Instruction on how to give client feedback was supported by role-playing experiences and the Rollnick

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[10] Although this description concentrates on Outreach's programs for adolescents, readers should also note that Outreach also operates a number of programs that are not focused on adolescent populations. These include two women's day-treatment programs, two outpatient substance abuse treatment programs, and a case management program for individuals who are HIV positive.

[11] NIAAA and CSAT jointly funded an RFA to stimulate greater progress in adolescent treatment research. See RFA AA-98-003 (note, however, that the deadline for responding to this RFA passed in 1998). CSAT has recently completed a 3-year study of Cannabis Youth Treatment and is currently supporting an evaluation of eleven Adolescent Treatment Models. Note that currently active NIAAA program announcements can be found at http://silk.nih.gov/silk/niaaa1/grants/program.htm while currently active CSAT program announcements can be found at http://www.samhsa.gov/grants/grants.html.

and Miller videotape (1998). There were discussions of the stages of change model, general principles of assessment testing, and using assessment results to develop a treatment plan.

These presentations were described as well prepared, informative, and good at clarifying unfamiliar concepts. Staff found the role-playing exercise to be particularly helpful. Staff reported that they felt prepared to administer the instruments and to give feedback to clients based on the presentations.[12]

However, the specific instruments presented during the visit were felt by the clinic director and clinic staff to be inappropriate for the Outreach context. The SOCRATES was felt to require a stronger background in the Prochaska and DiClemente perspective than the staff possessed. The other instruments were felt to suffer from two defects. They required too high a reading level for the Outreach clients, and they covered only alcohol use, whereas both alcohol and drug use (predominantly marijuana) are the focus of the therapeutic program. Therefore a decision was reached to select a different set of instruments more appropriate to the Outreach clients, administer those instruments, and give individualized feedback based on the results. In other words, although the specific instruments were changed, the conceptual model of administering standardized instruments and giving individualized feedback based on those instruments was preserved as the essence of the intervention delivered at Outreach.

This transition could not have been accomplished without the expertise of Outreach's vice president, who had an unusually strong research background and therefore was able to locate alternative instruments and population norms for those instruments. Most clinics would not have had access to this kind of expertise.

In the end, the assessment instruments used were the University of Rhode Island Change Assessment (URICA; McConnaughy et al. 1983); the Drug Taking Confidence Questionnaire (DTCQ; Annis et al. 1997a), an instrument developed at Toronto's Addiction Research Foundation to assess circumstances in which the client feels confident that (s)he can resist the urge to drink or take drugs (note: both are covered); and the Inventory of Drug Taking Situations (IDTS; Annis et al. 1997b), another Addiction Research Foundation instrument designed to identify situations in which the respondent usually consumes alcohol or drugs. Along with these, clinicians administered an "Outreach Family Services Client Assessment Form." This form, created for this project, collected information on alcohol consumption, drug consumption, and ages of first use that could be normed against adolescent populations studied by the Monitoring the Future Survey series (Johnston et al. 2000) and the National Longitudinal Alcohol Epidemiological Survey (Grant and Dawson 1997 and 1998).

As at other sites, staff turnover interrupted the project. Shortly after the researcher's visit, Outreach lost its treatment coordinator for the adolescent program, the outpatient clinic director, and the principal intake staffer (who would have administered the assessments). This meant that key staff members who had received the training departed, while remaining staff members had to stretch themselves thin to cover the duties of the departed staff. It also meant that there was not a front-line supervisor in place to monitor the progress of the intervention. As in other cases, these staffing problems made it hard to focus energy on the adoption of a new practice improvement, which was thereby delayed.

[12] It is an unsolved puzzle of this RiR project how the same researcher presenting the same material could be rated as very effective by one audience (Outreach Project) but as ineffective and too academic by another audience (SPARC). Rather than try to resolve this discrepancy, this summary simply reports the differing assessments given during the followup interviews with clinical staff.

In assessing the overall outcome of this project during the followup interview, a curious situation became apparent. The vice president was unaware of the degree of success that had been achieved[13]. According to the vice president, about eight assessments from each counselor's caseload had been administered and scored but none of the individualized feedback sessions had been held. However, two of the three counselors involved reported that, unbeknownst to the vice president, the individual feedback sessions had indeed been held, and they were found to be very useful.

Counselors reported that presenting the comparison between the client's alcohol use and that of the overall adolescent population, combined with the NLAES-derived probability of future alcohol dependence, was eye-opening without being confrontational. Furthermore, the scores from the drinking situations assessments helped counselors focus their therapeutic efforts on areas where the clients might most need help while at the same time allowing an opportunity to give encouragement and support about areas where clients scored somewhat better. Both techniques were rated as highly effective, and staff clearly expressed hope that the clinic would decide to continue using the assessments[14]. Since the vice president's position on the adoption of these instruments as standard Outreach practice was that a decision should rest on staff reports of their usefulness, the experiment is best described as a success in the making, whose adoption can reasonably be expected.

Several factors can be listed as promoting adoption to the extent that it was achieved. An effective presentation by the visiting researcher was reported in the followup interviews. The research skills of the vice president, which enabled him to locate alternative materials, were essential. The results of giving individual feedback to the clients were significantly positive and secured a belief on the part of the counselors that these techniques were useful therapeutic tools.

The main barrier to adoption was staff turnover. This distracted attention and delayed the progress of the intervention. Future rounds of this project need to bear in mind that staff disruptions are likely.

Another problem was the process of selecting intervention topics. The process of negotiating a match between the clinic's needs and the availability of solid findings was awkward and needs to be improved. However, the providers encourage NIAAA and CSAT to preserve the ability of the clinics to select interventions that best meet their needs.

Finally, some Outreach counselors had difficulty with the math required to use these instruments effectively. In part, this was acknowledged by the vice president's realization that he would need to do all the scoring for the counselors. It was confirmed when one counselor reported a previously concealed dyslexia with figures that impaired her ability to apply the instruments.

[13] Note that the departure of the outpatient clinic director meant that the intermediate link between the vice president and the front-line counselors had been broken.

[14] One counselor had administered additional assessments on her own initiative.

Future Directions for the Conversation between Practice and Research

During a final meeting, which was held to assess the lessons of this project and to approve this report (December 15, 2000), some important observations emerged. First, participants noted how far they had come toward holding a mutual conversation since the first meeting of the project. The initial meeting, while strong in cooperative intent, was marked by a sense of "us versus them," researchers versus providers. Each side was attempting to size up the other and to translate from the other's language into their own. The final meeting was marked by much less division between the two camps. Conversation flowed freely among participants without regard to which camp they had come from and within a common rather than a divided language. All felt equal contributors to an important mutual project. It was similarly observed that each side had been willing to make the cultural changes necessary for working effectively with the other.

After it had been noted that much progress toward having a common conversation had been made, it was further affirmed that it would be unacceptable to let this conversation lapse. Participants felt the need to keep the process going, consolidating and expanding the gains made thus far.

Part of keeping the process going includes connecting the experience gained in this New York phase of the project to its planned replication in North Carolina. While this report was drafted, in part, to capture lessons learned from New York for application in North Carolina, it was suggested that more direct contacts be established between New York participants and prospective North Carolina participants as a way of expanding the dialog beyond any one state-limited phase of the endeavor. Furthermore, participants in the New York experience would be invited to attend the planning meetings of the North Carolina project to provide some of their experience.

Equally important is continuing the process within New York State. OASAS and ASAP were especially concerned about whether we could institutionalize the process to provide additional opportunities for other New York providers to engage in projects like this one. Both OASAS and ASAP indicated considerable interest in follow-on projects for the coming year. CSAT's Practice Research Collaborative program, which has a very active network within the state, may provide a promising vehicle for this extension. All sides expressed an interest in participating in follow-on efforts.

Conclusions

In this final section, we summarize some of the observations that emerged across more than one site and thereby indicate more general conclusions.

1. ***Research-based improvements in clinical practice were achieved through a program of brief technical assistance visits by researchers.*** Providers were able to use these visits to introduce significant practice improvements at some of the RiR sites.

2. ***The implementation of research-based practice improvements can be difficult.*** Even though model clinics and leading researchers were chosen to participate in this program, adoption sometimes proved difficult. Given that a range of results was achieved, it is useful to inquire about the factors that contributed to or impeded adoption. Regarding the latter:

3. ***Staff turnover was a significant barrier to the adoption of research based improvements.*** Despite the fact that clinics were carefully selected, three of the six clinical sites experienced unforeseen and significant staff turnover that delayed or impaired the adoption of practice improvements. Future rounds of this program should plan for the likelihood of staff turnover.

4. ***Misperception that this project was a research study confused some providers about the project's goals.*** To the extent that the RiR program was seen as an outcomes trial, providers felt unable to comply with the project's data collection demands. NIAAA and CSAT need to keep emphasizing, in future rounds of this program, that only a technology transfer exercise and not an outcomes study is intended. This might be facilitated by formulating and stressing a precise specification of measures that would indicate that a successful practice adoption had occurred.

5. ***Substantial resourcefulness and leadership by clinic directors were required to promote adoption.*** At St. Mary's, significant energy had to be devoted to resolving the naltrexone reimbursement issue. At Outreach Project, the project probably would not have succeeded without the director's ability to locate alternative assessment instruments and the normative data for those instruments. At Buffalo, effective responses to staff turnover problems were critical. At all of the RiR sites, significant amounts of effort by the clinic directors and their staffs were required, whether or not these efforts produced the intended practice improvements.

6. ***The ability of researchers to communicate effectively with providers promoted adoption.*** In the followup interviews, the ability of the visiting researchers to communicate effectively with front-line staff and their appreciation of real-world operating conditions were the most frequently mentioned factors contributing to adoption. Unfortunately, the pool of top researchers who also possess these skills is small. This could set a limit on how widely this program can be expanded. It also indicates that there is a need for strengthening the communication skills of treatment researchers. NIAAA and CSAT should consider measures to enhance this capacity.

7. ***Uninterrupted leadership from the top level of the provider agency promoted adoption.*** Adoption of a practice change was impeded where the leadership for change was either interrupted by unforeseen events or was vested further down in the organizational hierarchy. Adoption was also impaired when mid-level supervisors were not available to communicate between clinic directors and line staff.

8. ***Changing clinical practice takes time.*** The original schedule for this project foresaw that researcher visits would be made in January and February, that 3 months would be required to adopt new practices, and that followup interview could be conducted in early June. Several sites needed much more time to put practice changes into place, and followup interviews were not held until August. In most cases, staff turnover was the major factor causing delay. Future rounds of the RiR program should plan with the expectation that such delays are likely.

9. ***Some practice improvements required greater change in existing counselor behavior than others.*** While all practice improvements required counselors to change their behavior to

some extent, the motivational enhancement intervention seemed to require substantial change in existing behavior at the site where it was tried. Thus motivational enhancement proved a somewhat difficult intervention to implement. In such cases, there may be a greater need for booster sessions to reinforce the original intervention.

10. ***The burden of existing information collections administered at intake is a barrier to adopting additional assessment tools.*** No matter how promising their potential benefits might be, the administration of new assessments necessarily conflicts with a rather substantial information collection load already in place in most clinics, much of it required for various reporting purposes. Furthermore, the scoring of assessment instruments is a considerable burden to clinical staff. These problems were of concern at both of the sites that implemented assessment instruments. Thought needs to be given to reducing the overall burden of information collection while improving the utility of the information that is gathered.

11. ***Flexibility was an asset in this project.*** Researchers and providers were left free to reach their own decisions about whether 1-, 2-, or 3-day visits would be required and whether a second booster visit (or a prior reconnaissance visit) would be helpful. In general, these choices were made thoughtfully and effectively. In addition, some sites added extra, experimental features to the program, such as the reverse visit at Catholic Charities and the press campaign at St. Mary's. These experiments often produced very helpful results. The program should try to preserve this flexibility.

12. ***Research findings were not always available to guide some improvements that providers wanted to make.*** NIAAA is encouraged to continue promoting research on the treatment of adolescents and persons with mental health comorbidities, both of which were shown to be areas of provider need for improved science by this experience.

13. ***Reimbursement problems did not prevent clinics serving economically diverse populations from offering naltrexone therapy.*** In both the St. Mary's and the Bellevue cases, ways to reimburse for the cost of naltrexone were found within the State's Medicaid program. However, determining which private managed care plans will reimburse for naltrexone is a job that needs to be tackled before many clinics will be able to move ahead with pharmacotherapy.

14. ***Existing treatment perspectives of the counseling staff were not a barrier to the administration of naltrexone.*** Contrary to expectations, objections to the general idea of using medications as an aid toward becoming alcohol-free did not emerge in any of the followup interviews with front-line counselors. In general, staff attitudes toward all of the interventions tried can be described as open minded. They were willing to give any promising approach a try, though they reserved skepticism about the ultimate worth of the approach until it was seen to work. Correspondingly:

15. ***Counseling staff tended to react positively to personal experiences of success with newly tried techniques.*** Findings in the research literature or statements of best practice standards meant relatively little. Front-line counselors became convinced of the worth of a new approach to treatment as a result of personal experiences of improvement in individual clients under their care. Projects to encourage technology transfer should be designed to reach this stage of individual success so that the intervention can take hold.

16. ***Both providers and researchers were enthusiastic about this program and valued its potential.*** Researchers who participated in the program valued the experience and generally would participate again if called upon. Providers valued both the specific knowledge transferred as well as the connections that were made to the research community. Providers would like to see this activity continued with follow-on efforts.

17. ***NIAAA and CSAT should continue to offer and develop the RiR program.*** There were both cases where adoption was stimulated and cases where adoption was not achieved at the six sites in New York State. However, the overall balance of results was positive. Both agencies should therefore continue to offer and to improve this program.

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