



CASE

CASE WESTERN RESERVE UNIVERSITY

Ohio Substance Abuse and Mental Illness
Coordinating Center of Excellence
OHIO SAMI CCOE

IMPLEMENTING IDDT

*A step-by-step guide to
stages of organizational change*



INTRODUCTION

The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring mental and substance use disorders.



Systems change
Organizational change
Clinical change

This booklet outlines the stages-of-change technology that the Ohio SAMI CCOE utilizes with policy makers, administrators, team leaders, service providers, community stakeholders, and steering committees to guide them through the process of implementing the Integrated Dual Disorder Treatment (IDDT) model. IDDT is an evidence-based practice (EBP) for people with co-occurring mental and substance use disorders (see Drake 1998, 2001 in Sources on page 38).

Each stage of change in this booklet contains expectations, strategies, and action steps that will help you fulfill incremental goals during

the implementation process. The stage-wise approach is important because it sets a realistic, manageable pace for achieving high fidelity to IDDT and improved outcomes.

This booklet serves three specific purposes:

- It provides a brief overview of all the stages of change and, thus, helps develop realistic expectations for the implementation process.
- It provides a benchmark for your current activities.
- It serves as a record (or checklist) of the incremental progress that you make over time.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

The stages of change are adapted from James O. Prochaska, et al., and the stages of implementation are adapted from Pamela S. Hyde, et al. (see Sources on page 38).

STAGES OF CHANGE

You are about to discover that the process of organizational change and service systems change is not much different than the process of personal change that your clients utilize on the road to recovery. The explanation is simple. Change is change, no matter what the setting or purpose. Individuals must be ready, willing, and able to do the work. They must also have support from people who will respect, evaluate, and encourage their efforts along the way. Consumers in mental health and substance abuse treatment find assistance from service providers who help them navigate their personal recovery journeys. Organizations and systems that implement service innovations find guidance from technical-assistance organizations (or other sources of technical support), which help them navigate a complex web of relationships and change processes.

There is a relationship-based clinical technology called *stages of change* that research has validated as effective for people who want and need to enhance the quality of their lives. The technology is based on the premise that change occurs incrementally over time through five stages—pre-contemplation, contemplation, preparation, action, and maintenance (see Prochaska and Connors in Sources on page 38). Thus, for people with co-occurring mental and substance use disorders, *big* changes like sobriety, symptom management, and an increase in independent living are built upon a series of *small, incremental* changes in their thinking and behavior. Likewise, for organizations and systems that are implementing IDDT, *big* changes like high fidelity and improved outcomes are built upon a series of *small, incremental* changes in philosophies, policies, and individual practices.

SUPPORTING RECOVERY

The IDDT model is not a conventional service that is implemented within organizations simply to respond to specific client needs, such as improving social skills, anger management, or personal health. IDDT is implemented to reinvent service systems, organizations, and individual clinical practices to support positive personal change and recovery among people with co-occurring mental and substance use disorders and their social support networks. IDDT is designed to enhance consumer outcomes, program outcomes, and system outcomes simultaneously. When you implement this service model, you begin with the desired outcomes in mind.

Core components

There are 12 organizational characteristics and 14 treatment characteristics of the IDDT model that are called *fidelity domains* (see page 5). These domains encourage systems and organizations to develop holistic integrated system structures and treatments that promote the physical, emotional, social, and economic well-being of people with co-occurring disorders. These core components also provide a structure for a continuous quality-improvement process that addresses both organizational and clinical outcomes. Research demonstrates that organizations generate improved outcomes when they maintain fidelity to the components of IDDT (see McHugo in Sources on page 38). In other words, successful implementation requires your personal and organizational commitment to positive change.

A COMMUNITY EFFORT

Successful implementation of IDDT is neither a top-down nor a bottom-up grassroots initiative. It is both. It depends upon involvement from many different people, including the following:

- State and county authorities (e.g., mental health, substance abuse, criminal justice, housing, and health)
- Agency and organization administrators
- Direct service providers
- Community stakeholders
- Clients
- Family members and friends who support clients in their recovery

Collaborating for change

Service systems, consumer groups, and community stakeholders who are typically involved with and/or affected by IDDT implementation include those listed below.

Systems & Groups	Stakeholders
Mental Health Services	<ul style="list-style-type: none"> ■ State mental health authority ■ Community-based mental health centers and providers ■ Crisis services ■ Inpatient state hospitals and community hospitals
Alcohol and Drug Addiction Services	<ul style="list-style-type: none"> ■ State alcohol and drug addiction services authority ■ Chemical dependency treatment programs and providers
Criminal Justice	<ul style="list-style-type: none"> ■ Law enforcement: police & sheriff's departments ■ Judges/Courts ■ Probation ■ Parole ■ Jails and prisons
Health Services	<ul style="list-style-type: none"> ■ Hospital emergency rooms ■ Primary care physicians
Vocational Rehabilitation	<ul style="list-style-type: none"> ■ State vocational rehabilitation (VR) authority ■ Vocational rehabilitation programs and providers ■ Business owners/employers ■ Employment programs within mental health agency or local community ■ Colleges and adult training institutions
Housing	<ul style="list-style-type: none"> ■ Homeless shelters ■ Group homes ■ Landlords/apartment owners ■ Other supported-housing
Education	<ul style="list-style-type: none"> ■ Colleges, universities, and training programs ■ General Education Degree (GED) programs ■ Supportive Education programs
Consumers/Clients	<ul style="list-style-type: none"> ■ Interested individuals
Family Members	<ul style="list-style-type: none"> ■ Client support networks (i.e., individuals who clients identify as close and important, which may include biological family members and others)
Advocacy Groups	<ul style="list-style-type: none"> ■ Representatives from consumer groups ■ Representatives from the National Alliance of the Mentally Ill (NAMI) ■ Other local, regional, and national advocacy groups
Media (The work of local media might assist with public education and consensus building.)	<ul style="list-style-type: none"> ■ Health, human service, and human interest writers, reporters, and editors in print, radio, television, cable television, and web-based media (i.e., commercial, public, and college media)

IDDT AT-A-GLANCE

NEGATIVE CONSEQUENCES

Individuals with co-occurring mental and substance use disorders are more likely to experience the following:

- Psychiatric episodes
- Use, abuse, and relapse to alcohol and other drugs
- Hospitalization and emergency room visits
- Relationship difficulties
- Violence
- Suicide
- Arrest and incarceration
- Unemployment
- Homelessness
- Infectious diseases, such as HIV, hepatitis, and sexually transmitted diseases
- Complications resulting from chronic illnesses such as diabetes and cancer

IDDT FIDELITY DOMAINS

The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring mental and substance use disorders and their families. The fidelity domains listed below are the core components of IDDT.

Organizational Characteristics

1. Program Philosophy
2. Eligibility/ Client Identification
3. Penetration
4. Assessment
5. Treatment Plan
6. Treatment
7. Training
8. Supervision
9. Process Monitoring
10. Outcome Monitoring
11. Quality Improvement
12. Client Choice

Treatment Characteristics

- 1a. Multidisciplinary Team
- 1b. Substance Abuse Specialist
2. Stage-Wise Interventions
3. Access to Comprehensive Services
4. Time-Unlimited Services
5. Assertive Outreach
6. Motivational Interventions
7. Substance Abuse Counseling
8. Group Treatment
9. Family Psychoeducation
10. Participation in Alcohol & Drug Self-Help Groups
11. Pharmacological Treatment
12. Interventions to Promote Health
13. Secondary Interventions for Treatment of Non-Responders



DESIRED OUTCOMES

IDDT Decreases

- Duration, frequency, and intensity of mental and substance use disorder symptoms
- Hospitalization
- Arrest and incarceration
- Duplication of services
- Treatment drop-out
- Utilization of high-cost services

IDDT Increases

- Abstinence from use of alcohol and other drugs
- Continuity of care
- Improved relationships
- Consumer quality-of-life
- Stable housing
- Employment
- Independent living



Resources

A description of the treatment characteristics may be found in this free booklet, which may be obtained online:

IDDT Overview

www.ohiosamcocoe.case.edu/library/emailresource.cfm?resourceid=87

Also consult these free resources:

IDDT Fidelity Scale

www.ohiosamcocoe.case.edu/library/emailresource.cfm?resourceid=107

SAMHSA (2003). *Co-occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit* (see Sources on page 38; this resource is commonly referred to as “The Toolkit”).

STAGE 1 PRE-CONTEMPLATION

Over 50 percent of people in the United States who have been diagnosed with a severe mental illness have also been diagnosed with a co-occurring substance use disorder.

— D. A. Regier, et al. (1990). Comorbidity of Mental Disorders with Alcohol and other Drug Abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, v264, n19, p2511-2518.



Unaware or
uninterested

This stage is defined by a business-as-usual atmosphere. Most mental health and substance abuse treatment systems and service organizations provide traditional (parallel or sequential) treatments. Clients must find help for each disorder in different departments or at different agencies, in different parts of town, with different service providers, often on different days. Services are frequently designed to respond to crises or to manage risks rather than to foster a full recovery process, including independent living and employment in the community. Administrators and providers may have an intuitive sense that this treatment structure is not working.

The idea to reinvent systems and service organizations at this stage often arrives as a disruption in current thinking, usually in the form of excessively high staff turnover or questions about unsatisfactory outcomes. The questions may come from any number of sources, including policy makers at state or county mental health and substance use authorities, local foundation representatives, agency administrators, service providers, community stakeholders, clients, or family members. At this time, most people in the organization are unaware of and see no need to change policies and practices.

Traditional services are frequently designed to respond to crises or to manage risks rather than to foster a full recovery process, including independent living and employment.

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1 ASK IMPORTANT QUESTIONS

Historically, people with co-occurring disorders have been excluded from mental health treatment because of their substance use disorder. Likewise, they have been excluded from substance abuse treatment because of their severe mental health symptoms. As a result, they frequently have not gotten the help they need.

It is important for administrators and service providers to ask if people with co-occurring disorders in their communities are currently receiving treatment for both disorders—preferably at the same time—and where. If you cannot answer this question and/or if you think these clients are being served adequately elsewhere, it is time to investigate.

If your organization does have a service program for individuals with co-occurring disorders, inquire about the outcomes of the program and its philosophies and practices. If the program is built upon a model that is not evidence based, it may be the right time for change.

Here are some questions to guide your investigation:

- Have you considered that your clients may have co-occurring disorders?
- How does your organization identify these individuals? Are there assessment instruments available?
- Do you know who these clients are and where they are being served?
- Do you know the daily-living needs and treatment needs of these clients?
- Do you collect, analyze, review, and share outcomes about this population?
- Are the outcomes for this population satisfactory to your organization, to your local community, and to your clients and their families?

2 BEGIN THE CHANGE PROCESS

The contemplation stage outlines nine steps that will help you consider if the IDDT model is right for your organization and community (see page 8).

STAGE 2 CONTEMPLATION

“At some point, someone has to think about making use of an innovation. This requires some degree of awareness that leads to acquisition of information and exploration of options.”

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, p15.



Consensus
building

This stage is characterized by thinking about and evaluating the advantages and disadvantages of implementing IDDT, exploring your concerns about the process, and engaging in a relationship with a technical-assistance organization (or another source of support) to access the lessons that have already been learned by other service systems and organizations. All of these activities will help you evaluate your readiness, willingness, and ability to begin the implementation process. The activities will also demonstrate that you are not alone. You do not have to repeat the same mistakes that others have made.

Full implementation of IDDT creates big changes incrementally over time. Managing these changes requires a significant investment of time, energy, and human resources—and sometimes financial resources. Therefore, you need to know what to expect. IDDT programs provide services for both mental and substance use disorders in the same place and with the

same treatment staff, who help clients address both issues at the same time. To accomplish this, many administrative and clinical components of service systems and organizations need to be reevaluated, rearranged, reinvented, or refinanced. Use this section of the booklet to engage in some serious administrative introspection about implementation.

Keep in mind that you should not try to rush through the implementation process. Many successful IDDT programs have taken an entire year to complete the contemplation and preparation stages (see chart below). The pace of implementation is different for every organization. It is useful to proceed carefully and deliberately (see Tip on page 13).

From time to time, ask members of your organization an important question about IDDT implementation: “Is this what we want to do?”

Evaluate your readiness, willingness, and ability to begin the implementation process.

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| 4 | EXAMINE YOUR MISSION, VALUES, GOALS, AND VISION | 9 | EXPLORE CONCERNS |
| 5 | CHECK IT OUT | | |

1 CONDUCT A NEEDS ASSESSMENT

The motivation to change your policies and practices must ultimately come from inside your system or your organization. Otherwise, there will be a lot of resistance and little change. It is important that you and your community arrive at your own informed conclusion about the service needs and outcomes of people with co-occurring disorders in your region. Be aware that leaders may be reluctant or unable to address the service needs and outcomes. You might not have a mechanism for collecting, evaluating, reporting, and discussing the significance of the data. Conduct your own comprehensive Needs Assessment. It will help get you started.

A comprehensive assessment identifies consumers with severe mental illness and co-occurring substance use disorders who will benefit from IDDT. It then identifies *all* of the service needs of *all* clients in your agency and community. It also identifies which services your clients do and do not utilize. To get this information, system administrators typically involve many stakeholders. Agency administrators involve all departments in their organization and all community stakeholders who might interact with clients (see stakeholder list on page 4). Ask them to report the following about their interactions with your clients:

- Types of service used
- Frequency of service use
- Duration of service use
- Costs for current service utilization

The Needs Assessment also requires you to ask your clients and their family members about service utilization and quality-of-life outcomes.

2 DEVELOP AWARENESS OF AVAILABLE OPTIONS

Evaluate the results of your Needs Assessment. Which client groups experience the greatest need and the most problematic quality-of-life outcomes? Which client groups are the most expensive to serve? Plan to direct your policy and practice innovations toward them. If the outcomes for people with co-occurring mental and substance use disorders are the most negative, conduct your own research of all available service innovations that will benefit them, including EBPs. However, if these clients experience significant rates

of recovery with your current practices, there may be little need for change, especially if you are keenly aware of the factors that contribute to the positive outcomes. If this is the case, be sure you have mechanisms in place to maintain these practices.

There are many options available to enhance services for people with mental and substance use disorders. Analyze all options and choose one that fits the needs of your region or community. For instance, there are several EBPs that have been designed and tested for a variety of mental disorders as well as for dual disorders. Some of these EBPs include the following:

- Assertive Community Treatment (ACT)
- Integrated Dual Disorder Treatment (IDDT)
- Supported Employment (SE)
- Illness Management and Recovery (IMR)
- Family Psychoeducation (FPE)
- Medication Management Approaches in Psychiatry (MedMAP)

3 IDENTIFY CURRENT PRACTICES AND RATIONALES

Before you reach the conclusion that you need IDDT, establish a rationale for it. Compare the policies, structures, and outcomes of your current practices with the EBPs that you have researched. Is there potential for improvement with the EBPs? Subject your status quo to your own analysis. Ask yourself and key stakeholders an important question: “Why do we provide services this way?” If your answer is “because we’ve always done it like this,” ask another important question: “Are we making every effort possible to help our clients strive to achieve *their* greatest potential for living independent, satisfying lives in the community?”

4 EXAMINE YOUR MISSION, VALUES, GOALS, AND VISION

- What is the purpose of your system or agency?
- What outcomes do your clients and their family members want to achieve?
- What assumptions do you make about your clients?

5 CHECK IT OUT

Before you spend any money or ask your staff to throw out the old to make room for the new, prepare yourself, your service system, and your organization with information. It will help everyone manage their anxiety about potential failure, and it will help everyone manage practical concerns about providing and funding services. Here are a few things you can do to develop realistic expectations about the challenges and successes ahead.

Common elements of evidence-based programs

- Clear philosophy, beliefs, and values
- Specific treatment components (treatment technologies)
- Treatment decision making (within the program framework)
- Structured service delivery components
- Continuous improvement components that encourage innovation

—Dissemination Working Group, 1999 (see Fixsen, et al., p27 in Sources on page 38).

Review the literature

Consult published literature about EBPs. Some criteria that define the literature are included below as a brief and general overview to inform your search. References to more information about the criteria are also provided. A useful resource for this step of implementation is “How to Read and Understand the Literature” in *Turning Knowledge into Practice* by Pamela S. Hyde, et al. (see Sources on page 38).

- **Relevant and objective outcome measures**
EBP research examines client outcomes, organizational outcomes, and systems outcomes and, thus, identifies administrative practices and clinical practices that improve quality of life for consumers and their families and improve service success and cost-savings for organizations and service systems.
- **Controlled research**
This refers to the design of the research studies that have examined the administrative practices and clinical practices that became the evidence-based practice. Controlled research typically includes these key components: clear hypothesis; rigorous methods; controlled conditions; participants who have similar attributes (e.g., diagnosis, income, level of education, etc.); random assignment of research participants to an experimental group (in which the new practice is used) and a control group/non-experimental group (in which the old practice is used); a large number of participants (to eliminate the possibility of “chance” results); internal validity; external validity; reliability; statistically significant results of the comparison of the outcomes from the experimental group and the control group.
- **Replication**
EBPs have been studied with more than one research group. In other words, improved consumer outcomes, program outcomes, and system outcomes have been replicated in different settings, with different clients, and by different researchers over time (i.e., across differing agencies/organizations, regions).
- **Standardized treatments**
EBPs have organizational characteristics (administrative components) and treatment characteristics (treatment components) that are called fidelity domains (see page 5). Organizations that maintain fidelity to the EBP produce improved outcomes. Fidelity domains are not prescriptions or step-by-step instructions for how service providers must interact with clients. Rather, fidelity domains create organizational and treatment frameworks in which providers can maximize the benefits of the most effective approaches currently available.

(For more information, see Figure 2 on page 37.

Also, consult the following in Sources on page 38: SAMHSA 2003, p1-7; Pamela S. Hyde, et al., p31, 34-36, 104-107; Robert E. Drake 2004, p361.)

Interview other programs

Talk to people at existing IDDT programs who have already gone through the implementation process. They will give you real-life examples from their experiences.

We suggest you talk to the following:

- Mental health and substance abuse authorities
- Agency/program directors
- Clinical directors
- Team leaders
- Direct service staff (service providers)

Here are some questions to ask:

- What have been the most significant benefits of implementing IDDT?
- What were the most challenging barriers you experienced during implementation? How did you overcome these barriers?
- What are your top three barriers to sustaining IDDT? What are your plans for overcoming these barriers? How did you identify and decide upon these strategies?
- If you were going to implement again tomorrow, what would you do the same and what would you do differently?

(To connect with your peers at other IDDT programs, contact the Ohio SAMI CCOE or consult the EBP Program Locator database on our web site: www.ohiosamiccoe.case.edu/ebpprograms)

Attend a training

Attend an introductory training to enhance your knowledge of IDDT and to build a network of peers with whom you may consult in the future.

Visit a high-fidelity program

After you have completed reading about IDDT and have talked to a few peers on the telephone and at training events, take a field trip to a high-fidelity program. Start by interviewing the person at the state or county authority or agency who has a similar position as you. This person will have a collegial (or “street-level”) credibility that you will not get from books or presentations. The visit will give you a *feel* for what IDDT is all about. It will add experiential data to your research.

(Participate in a free online implementation network: www.ohiosamiccoe.case.edu/training/messageboard_fr.html)

continued on next page

6 ENGAGE TECHNICAL ASSISTANCE

Technical-assistance organizations and other support services can help you avoid repeating the same mistakes that others have made. They can also evaluate the barriers that are unique to the culture of your system, your community, and your organization and make recommendations for changes that are based on experience. Technical-assistance consultants work closely with your organization to transform your administrative and service environments to support and promote *integrated* mental and substance abuse services. There are typically two types of consultation, which are described below. Use the following tips and questions to prepare for engaging technical-assistance organizations and other forms of support.

- Make a list of your top 10 concerns about IDDT.
- Is there a technical-assistance organization in your state to help you alleviate or address your concerns?
- Does the substance abuse or mental health authority in your county or state provide technical support, or will it provide financial assistance to help you acquire it?
- Do you have funding to send your staff to training?
- Does the technical assistance organization in your state provide onsite training that is customized for the knowledge and skills of your staff?

Organizational consultation

This form of consultation focuses on the entire IDDT Fidelity Scale, including the 12 organizational characteristics and 14 treatment characteristics (see page 5). Consultants provide a number of ongoing services, including the following:

- Encourage a manageable pace for implementation by keeping your focus on the stages and steps outlined in this booklet.
- Help you make informed decisions by providing examples of lessons learned from other IDDT programs.
- Remind you of the importance of pursuing and maintaining collaborations with community stakeholders and other systems that provide essential services, such as housing, employment, criminal justice intervention, and peer supports like 12-step groups, among others.
- Assist your steering committee in its efforts to provide oversight.

Clinical consultation

This usually occurs in the action stage of implementation.

Resistance to change can be minimized by listening, sharing ideas, and developing consensus.

7 ASSESS THE PROS AND CONS

Use the information that you have collected thus far to re-evaluate your Needs Assessment. Do people with co-occurring mental and substance use disorders in your community, in fact, need an innovation in service? How does IDDT address this innovation? Here are some items to consider as you evaluate the pros and cons of IDDT:

- Refer to your Needs Assessment (see page 10) and list each need of your clients, staff members, and community stakeholders; does IDDT address these needs?
- Which people, programs, or organizations in your system, community, or organization could be re-trained, re-organized, or re-financed to move toward IDDT implementation?
- Briefly describe the strengths of your organization that will facilitate the implementation of IDDT.
- What are the barriers in your system, community, or organization that will prohibit the implementation of IDDT?
- How can these barriers be overcome?
- Is there technical assistance available to help enhance current strengths, to develop new strengths, and to help eliminate barriers?
- Briefly describe the source, depth, accessibility, and expertise of the technical assistance that is available.
- What is the estimated cost?
- Are there sources of funds available from the following: your organization, community stakeholders, foundations, or county, state, and the federal government?
- Can you manage this innovation without special funding?
- Have peer organizations overcome these same barriers (e.g., refer to your notes from your telephone conversations and site visits)?
- Who are your peer contacts?

8 DEVELOP INFORMED CONSENT AND CONSENSUS

The assessment you conducted in the previous step helps you clearly understand the benefits and risks of implementing IDDT and, thus, helps you develop informed consent and consensus in your organization about your decision to proceed. Be sure to involve senior management and a cross section of service providers and consumers in your service system and/or organization while you are contemplating change. IDDT will require systems and organizations to change their policies and procedures. The people with authority to make these changes must be informed if they are going to agree to participate. In addition, high-level managers at organizations will have more success talking to community stakeholders like judges, police chiefs, and hospital CEOs, all of whom will be important collaborators who will contribute to the implementation effort.

While developing consent and consensus in your system or organization, pay particular attention to IDDT’s fidelity domains (see page 5). On the road to achieving improved outcomes, fidelity drives the bus. The fidelity domains will challenge you to reexamine every aspect of your business. Here are some examples of administrative changes you will face:

- Client eligibility for service (Axis II vs. Axis I diagnoses)
- Billable-time policies (e.g., for assertive outreach, training)
- Relevant outcomes and performance (e.g., client movement through stages of treatment, abstinence from substances, employment, housing, quality of life) might replace unit-of-service productivity as a means to measure performance
- Documentation of policies and procedures
- Clinical documentation format (e.g., screening tools, assessment, treatment plan)
- Organizational structure (e.g., lines of supervision and reporting; types of services offered; providing programs vs. providing team-based services)
- Team constellation and staffing (be careful not to eliminate positions until you understand how they might serve the IDDT team)
- Job descriptions
- Physical space (e.g., for groups, shared offices for teams)
- Transportation issues (e.g., for groups)
- Time commitment (e.g., steering committees, technical-assistance consultation supervision)

9 EXPLORE CONCERNS

For every barrier that you identify in the previous step, continue to be persistent about your research. When in doubt, call upon your technical-assistance organization and compare what they have to say with what your contacts at the high-fidelity programs had to say when you visited them. Also, ask your community stakeholders how they might help you overcome the barriers you have identified. By asking them for help, you may inspire a shared sense of purpose—a true partnership.

Cost and cost-shifting is typically a concern. Know that there are IDDT initiatives in Ohio that started with a variety of funding arrangements. Some Ohio programs acquired seed money from state and federal grants. Some found resources from local foundations. And some found resources of their own by restructuring their organizations. So don’t let the perceived cost of IDDT implementation hold you back from moving along. You will explore cost issues in more depth on the following pages (see the “Identify financial resources” section on page 18).



Change is not a linear process. People and organizations move back and forth through the stages, which creates an overlap or spiral effect. As a result, it is often difficult to clearly define the stage of change in which an individual or organization functions.

In addition, individuals who are participating in an organizational change process are often in different stages of personal change. For instance, not everyone will agree at the same time that IDDT is a necessary innovation. The lack of consensus influences progress. Thus, organizational change is more complex than individual change. There are many forces that affect the speed and quality of the implementation process.

Resist the temptation to focus on the barriers to innovation. There will always be risks and barriers, but there is evidence that client outcomes, program outcomes, and service system outcomes will improve as a result of IDDT. Remind yourself of the positive outcomes that can be achieved (see page 5).



STAGE 3 PREPARATION

“Broad-based community education and ownership that cuts across service sectors is critical to installing and maintaining an evidence-based program with its unique characteristics, requirements, and benefits.”

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, p15.



Motivating

In this stage, your work will focus on motivating people in your organization, other organizations, other service systems, and the local community to recognize the value of IDDT and to join the implementation effort. You will also provide stakeholders with opportunities to contribute their experience, expertise, and resources to the process. You will use all of the research you conducted in the contemplation stage to communicate the following clearly and concisely to multiple audiences as you invite them to participate and develop a long-term collaboration:

- Importance of including IDDT principles in mission statements (of organizations and service systems)

- Prevalence of co-occurring mental and substance use disorders in your community
- Impact of co-occurring disorders on clients, operations, and systems
- Current outcomes and service needs in the community
- Targeted outcomes of IDDT (i.e., consumer, program, and systems outcomes)
- IDDT principles and implementation process
- Existing barriers to change in the community and in service systems
- Existing facilitators of change in the community and in service systems
- Potential collaborators for the change process

Motivate others to contribute their experience and expertise to the implementation process.

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1 DEFINE YOUR RATIONALE

Before you proceed any further, clearly define why IDDT is necessary for your organization and the service systems in your community and region. Examine your mission statement and make sure it is aligned with the principles of integrated treatment. If it is not, consider changing it and be prepared to explain the changes to people in your organization and community. It will enhance their understanding of the innovation. IDDT principles will have more influence if they are included in the mission and values of your organization.

2 IDENTIFY STAKEHOLDERS

To achieve and sustain high fidelity and improved outcomes, you will need many different people to contribute their passion, talent, and expertise to the project. Therefore, it is important to recruit representatives from your organization, from other organizations and systems, and from the community at-large to participate in a steering committee or advisory group. They will guide the implementation process by giving voice to the ideas, concerns, and experiences of those who make policies, provide services, and receive help.

Before you pick up the phone, though, think strategically about those who will make the most valuable contributions to the implementation process. You will need a balance of people who have knowledge of *and experience* with policy making, service provision, and service utilization. You will also need to include those who have access to financial and political resources. It is an effective strategy to assemble a steering committee or advisory group that is small. Smaller groups can accomplish more in a shorter time frame. You can invite more people to join the group as the implementation process evolves.

Be mindful of politics

Recruiting stakeholders for a steering committee or advisory group is a practical and political process. In every system and community, there are power dynamics and relationships. Be mindful of them and know that there may be potential collaborators who have a troubled history, with failed collaborations. Therefore, engage each individual and group with a positive attitude. One way to stay upbeat and hopeful is to remain focused on the common interests of the group, including improved outcomes that high-fidelity IDDT services generate (see page 5). Put yourself in the shoes of the people you are approaching and ask yourself an important question: “What is in it for them?” Highlight the improved outcomes but refrain from an exclusive use of statistics.

Whenever possible, present statistics with a human face: share a few real-world success stories from the programs that you visited in the contemplation stage. This will remind your collaborators that you are all in the business of helping people with co-occurring disorders and their family members improve the quality of their lives.

Assemble a long list of names

In the brainstorming phases of projects like this one, it is productive to get all of your ideas out “on the table” and in writing, where you and your initial planning group can see them and evaluate them. Assemble a long list of all the stakeholders who might be good for your steering committee or advisory group. Start by including a representative from each stakeholder group that you identified in your Needs Assessment (or consult the list on page 4). Many of these people will be interested in the IDDT service innovation, because they will benefit in some way from improved outcomes.

Evaluate and choose the best candidates

Transform your list of stakeholders into an evaluation tool. Ask the questions below about each person to evaluate if he or she is ready, willing, and able to make a contribution. Rank your candidates. In the end, make sure each stakeholder group is represented.

Ready

- Demonstrates an investment in or expresses a sincere desire to improve care for this client population? (Y/N)
- Accurately and assertively represents his/her constituents? (Y/N)

Willing

- Has a reputation for working cooperatively with others? (Y/N)
- Is willing to refer clients with co-occurring disorders to the IDDT service team? (Y/N)

Able

- Communicates ideas effectively?
- Has a reputation for encouraging ideas and supporting people through change? (Y/N)
- Has access to resources that will benefit the cause (i.e., knowledge, people, money)? (Y/N)
- Has the power to influence policy changes in systems or organizations? (Y/N)

3 BUILD CONSENSUS

The implementation advisory group or steering committee within an agency should eventually consist of community stakeholders, agency managers, consumers, family members, and direct service providers. Make an initial presentation to each group and solicit their ongoing feedback and questions. It is useful to approach each group and every individual from the stages-of-change approach (see page 3). Remember that individuals must be ready, willing, and able to do the work of reinventing service systems, organizations, and clinical practices. Some people may jump directly to the preparation stage with you. Others might need some time for contemplation. Yet, others may be stuck in the business-as-usual mindset that defines pre-contemplation. Note that their unwillingness to change may be one of the biggest barriers to your success. Find a way to work with them or, perhaps, around them at first. Technical assistance from an outside group can provide helpful suggestions.

At some point in the consensus-building process, you might consider using a helpful tool like “The Evidence-Based Practice Attitude Scale (EBPAS)” to assess the openness and willingness of individuals within your organization to commit to IDDT implementation (see Aarons in Sources on page 38).

Administrative consensus

Top or upper-level managers in organizations have the authority to change policies to support IDDT practices. Therefore, they must be included in the process. If an organization places the responsibility of implementation upon a clinical team leader, there will be problems. He or she is likely to run into a number of administrative barriers that only managers can change. For example, an aggressive productivity policy for case management is likely to prohibit a team from conducting effective outreach with clients who are in the *pre-contemplation* stage of personal change and the engagement stage of treatment (see list in “Develop informed consent and consensus” section on page 12 for additional examples). In addition, top or upper-level managers will have more success accessing and convincing community stakeholders like judges, police chiefs, and hospital CEOs to collaborate. Include the following on the implementation steering committee or advisory group:

- Chief executive officer
- Chief financial officer
- Clinical supervisors and managers
- Appropriate clinical team leaders
- Service providers (e.g., case managers)
- Quality improvement/assurance officer
- Information systems officer

Staff consensus

It is more important to assemble a team of IDDT service providers who are committed to the philosophies of integrated treatment than to assemble a team of providers who simply have many years of experience. Staff members who are accustomed to providing services “the old way” may be resistant to change. It is not time yet to recruit team members. However, it is time to identify the best candidates. Let your staff know that the organization is preparing to implement IDDT. Be clear about IDDT’s client-centered stage-wise approach and help each staff member assess its pros and cons. Encourage them to do some serious soul-searching and to ask themselves if this is what they really want to do. Potential team members are those who truly embrace client-centered stage-wise integrated treatment. Their enthusiasm and hope will propel them and their clients to success. Be prepared to provide access to extensive training. Know that in some cases, you might have to recruit IDDT team members from other departments within the agency or from outside the organization. The team leader will work with the program administrator to recruit team members (see pages 19-20).

Community consensus

As you engage community stakeholders, provide information about IDDT to them so that they begin to understand IDDT’s basic principles, including stage-wise approach to treatment (i.e., engagement, persuasion, active treatment, relapse prevention). Remember that IDDT providers help clients find their own motivation to change gradually over time with social support. Be prepared to answer questions about the principles of IDDT (see list of fidelity domains on page 5).

Community stakeholders may need to rethink how they interact with clients who have co-occurring disorders and how they interact with your organization. For instance, in the past, the local court may have referred clients to your organization with the expectation that they will achieve sobriety in 30 days. IDDT’s success is based on a stage-wise approach over longer periods of time. It does not demand that clients meet unrealistic short-term expectations that are imposed upon them. Ask each stakeholder if he or she is open to learning more about IDDT and contributing to this effort. Presuming they may initially be skeptical, provide stakeholders with information in print and in person about the outcomes that can be achieved with a high-fidelity program. Also remind them that high fidelity depends upon cooperation from the community—namely, them.

(Use the *IDDT Overview* booklet to help build consensus: www.ohiosamihcoe.case.edu/library/emailresource.cfm?resourceid=87.)

continued on next page

4 FIND YOUR IDDT “CHAMPIONS”

IDDT champions are people within your organization who have an unwavering enthusiasm for and commitment to IDDT treatment principles, fidelity, and outcomes. They are the heart-and-soul of implementation—the leaders whose enthusiasm will inspire others on an interpersonal level. The champions are involved in all aspects of implementation. They attend steering committee meetings and treatment team meetings, read the fidelity reports, and request training for team members. They stay in contact with peers at other programs and often represent your organization at regional and statewide meetings. In short, IDDT champions are part enthusiasts, part overseers, and part advocates. They keep the energy, focus, and motivation alive and vibrant. If your IDDT champions are not administrators, they will need the support of a high-level manager who will ensure that the policies of your organization support the cause.

5 IDENTIFY FINANCIAL RESOURCES

Create a list of all the IDDT services that you will provide in the four stages of treatment (see Figure 1 on page 36) and identify a source of income for each. This will help you evaluate your revenue streams and identify missing sources of income. For instance, some service activities like outreach (in the engagement stage of treatment) and multidisciplinary team meetings might not be billable to some insurance programs or other funding sources. Therefore, you will need to find another source of income to cover these expenses.

Be prepared to make presentations to community stakeholders who will benefit financially from a reduction in service utilization by people with co-occurring disorders. You might convince them to contract with your agency for some of its services. Also make presentations to other potential funding sources, such as the United Way and local foundations and keep an open mind about unorthodox sources that might be available in your community. Ask around. Maybe there is a professional athlete or a successful business owner who is invested in helping people with mental illness or co-occurring mental and substance use disorders: they might be interested in contributing to the IDDT cause.

Contact other IDDT providers in your peer network for advice. Ask them how they have arranged their budgets to ensure income for IDDT services. Here is a list of possible funding sources:

- Insurance reimbursement (e.g., Medicaid, Medicare, private insurance)
- Mental health authority
- Substance abuse authority

- Other public systems that work with the co-occurring population and will benefit from improved outcomes (e.g., criminal justice system, hospitals)
- Grants from government sources (e.g., federal, state, county, local)
- Gifts and grants from private benefactors (e.g., foundations, entrepreneurs, industrialists, athletes, entertainers, estates)

6 ASSEMBLE A STEERING COMMITTEE

By now, you have identified a number of individuals within your organization and community who may be interested in IDDT and working cooperatively with others. It is time to invite them to be a part of your implementation steering committee. The committee will help your organization stay focused on implementing and sustaining a high-fidelity program over time. Steering committees consist of community stakeholders and an internal work team of individuals from your organization.

The *internal work team* consists of the IDDT program manager and team leader, service providers, and key organizational administrators (e.g., chief executive officer, chief financial officer, chief information technology officer, clinical director, quality-improvement staff) who collaborate with *community stakeholders* (see page 4). This team takes most of the responsibility for developing the multidisciplinary service team, reviewing team performance, and reviewing and monitoring fidelity action planning and outcomes. The community stakeholders tend to take a macro approach to their work. They help the organization identify needed support and resources then work within the systems that they represent to provide that support (e.g., housing networks, employers, criminal justice/probation officers). In addition, committee members work to minimize barriers between systems and to build bridges between the IDDT team and consumer groups like NAMI.

Committee activities

The steering committee (and the internal work team) oversees a number of activities, which include the following:

- Review results of the Needs Assessment (see page 10)
- Identify, select, and track desired client outcomes, agency outcomes, and systems outcomes (see page 26)
- Review the fidelity report (see page 24)

- Develop a broad-based implementation plan (see page 21)
- Develop a fidelity action plan with specific action steps for each EBP component (see page 24)
- Identify and minimize organizational barriers and systems barriers to implementation and fidelity (see page 27)
- Plan a “kickoff” event for stakeholders to educate them about and to build enthusiasm for IDDT (see “Begin an implementation plan/Raise awareness” on page 21)
- Review and recommend enhancements to administrative policies and practices (e.g., billing, treatment plans and documentation)
- Review outcome reports at least quarterly (see page 26)
- Monitor quality improvement
- Identify and pursue sources for funding, as needed

7 CONDUCT A READINESS ASSESSMENT

The Readiness Assessment is conducted by your technical-assistance organization. It is a discussion with your internal work team about the key components described on the previous pages that are required for successful implementation. The assessment ensures that you have begun to consider and assess everything you need for your journey. It checks for the following:

- Impressions about the need to change
- Factors that influence interest in adopting the EBP
- Support for implementation within the organization and from local, county, and state authorities
- Recent experiences with adopting service innovations
- Information from the Needs Assessment
- Current treatment philosophy
- Presence of an existing work team/steering committee
- Current and projected outcomes
- Current service array, service team, and program structure
- Staff knowledge and expertise base, attitudes, and openness to change
- Administrative and clinical supervisory structure
- Consumer and family member involvement in service planning and delivery
- Financial health and funding resources for implementation
- Collaborative potential
- Awareness of key IDDT principles and implementation processes
- Overall readiness

8 DECIDE TO IMPLEMENT OR NOT

The Readiness Assessment is designed to provide you and your technical-assistance consultants with enough information to make a collective decision to proceed with implementation or not. Some organizations may need to

acquire additional human and financial resources before beginning the process. It is important to be prepared adequately for implementation.

Encourage your implementation team to ask the following questions to decide whether your organization is ready to implement or not:

- Is there consensus to implement?
- Is this the right time to initiate organizational change?
- Do we have the time and energy to dedicate ourselves to the entire implementation process?
- Are we confident that we have the necessary financial support to provide IDDT services?
- Are we prepared to address organizational policy and procedure changes?

9 RECRUIT A TEAM LEADER

Once you decide to proceed, it is time to formally recruit your IDDT team leader—if you have not already done so. This person is responsible for building and maintaining the service team. He or she is somebody who is comfortable working with a variety of professionals and fulfills a multifaceted role that combines interpersonal, administrative, and clinical skills. The team leader is responsible for hiring staff, providing administrative and clinical supervision, fostering communication among team members, and encouraging resolution when disagreements about treatment strategies arise. The team leader is a champion of the practice and, therefore, must be skilled in developing, training, and coaching staff members. The team leader meets one-on-one with team members, leads team meetings, facilitates ongoing clinical training, and represents the team at administrative meetings and steering committee meetings. Some team leaders also maintain a small caseload to keep themselves in touch with clinical and programmatic issues that affect consumers, caregivers, and treatment team members.

For more information about the role of the team leader, consult these resources:

- www.ohiosamimccoe.case.edu/training/teamleader/teamlead.html
- www.ohiosamimccoe.case.edu/news/samimatters2001spring.pdf (see pages 8-10 of this pdf)
- Mercer-McFadden (see Sources on page 38)

continued on next page

10 PLAN TO START SMALL

The Needs Assessment that you conducted in the contemplation stage identified the total number of clients in your local mental health and substance abuse systems who might benefit from IDDT services. You should not try to serve all of them at once. Instead, work with a small subset. For instance, if you identified 1,000 eligible clients, start by serving 50 with one team of providers. There is a practical reason for this approach. If your IDDT program is small, the impact of the barriers that it experiences will tend to be small and, therefore, manageable. On the contrary, if your fledgling program is large and involves many team members and clients, the impact of barriers will be large and possibly disruptive or problematic to the organization. Once the initial service team achieves at least moderately high fidelity and improved outcomes with the initial group of clients, you will make plans for an incremental expansion of the services. This typically occurs in the maintenance stage of implementation (see “Expand IDDT Services” on page 31).

Some organizations in Ohio have implemented IDDT on a large scale (e.g., with multiple teams serving many clients). However, the unintended consequences of implementation—which can and do occur—affected a large number of people within and served by the organization. Thus, the lessons learned during implementation were more painful than they might have been with a small initiative.

11 ASSEMBLE THE MULTIDISCIPLINARY SERVICE TEAM

The IDDT model views all activities of life as part of the recovery process. Therefore, the model provides each client with a variety of service providers to help him or her in all aspects of life. The team consists of the following:

- Team leader
- Case manager(s)
- Mental health counselor
- Substance abuse specialist
- Criminal justice specialist/liaison
- Employment specialist
- Housing specialist
- Nurse
- Psychiatrist/physician
- Family specialist

One of the first tasks of the IDDT team leader is to work with program administrators to recruit members of the multidisciplinary service team. Implementation experiences in Ohio indicate that the most effective (i.e., collaborative) teams are formed when the new IDDT team leader interviews and selects his or her own staff (with input and oversight from upper management). In the staff-consensus section on page 17, you identified

potential candidates for the job—that is, service providers who are committed to IDDT’s client-centered stage-wise integrated treatment approach. Use the list of names to recruit team members and remember that in some cases, you might have to recruit from other departments within the agency or from outside the organization. Remember that it may be helpful to use “The Evidence-Based Practice Attitude Scale (EBPAS)” to assess the openness and willingness of potential team members to commit themselves to IDDT implementation (see Aarons in Sources on page 38). Team leaders should work with each team member to develop individual professional development plans. They should shadow team members in the community and be prepared to model new practices and coach providers as they work to integrate new knowledge and skills into practice.

The multidisciplinary treatment team meets daily to discuss pressing issues and meets regularly to discuss each consumer’s progress in all areas of his or her life. Team members use formal and informal meetings to provide insight and advice to one another. They meet individually and as a group with each client and their caregivers (family, friends, and other supporters) to discuss the client’s progress and goals. Successful IDDT programs coordinate all aspects of recovery to ensure that consumers, caregivers, and service providers are working together toward the same goals in a collaborative manner. When necessary and appropriate, team members may “fill in” for each other to provide clients with services they need in a timely manner. For instance, nurses may provide case management services when delivering medication to clients in community locations.

The ongoing cohesiveness and success of the multidisciplinary team depends a lot upon the team leader’s and the program manager’s ability to utilize effective recruitment strategies, to make smart hiring decisions, to execute retention initiatives (such as ongoing training), and to be prepared for staff turnover. Be on the look-out for potential team members. Invite service providers within your organization who are not members of an IDDT team to training sessions and consultations. If they express an interest and enthusiasm for IDDT, they may be a future candidate for the team.

(For more information about identifying and recruiting potential team members, see the “Build consensus” section on page 17.)

12 BEGIN AN IMPLEMENTATION PLAN

The Implementation Plan is your organization's to-do list of practical needs for the start-up of your IDDT program. The Implementation Plan is not an auditing or accreditation tool. Nor is it specifically related to fidelity. The Plan is utilized by your steering committee and other committees to guide the process until the Fidelity Report and Fidelity Action Plan have been written (see page 24). Your technical-assistance organization (or other source of technical support) will help you develop the Implementation Plan, which is a matrix that consists of four major components:

- Implementation item
- Task required
- Person or group responsible
- Deadline for completion

Raise awareness

Now that you are ready to begin the action stage of implementation, it is time to celebrate this new era of service innovation with all stakeholders in the community (see table on page 4). Invite them all to a “kickoff” event. Take time to describe again the core components of the model, expected outcomes, and the benefits of the outcomes for clients, their families, and the community at-large. Be sure to emphasize that it is not just your organization which is implementing IDDT. *Implementation is a community effort.* Remind stakeholders that the success of IDDT depends upon active participation by and collaboration with all of them. IDDT is about community investment and change.

A kickoff event educates community stakeholders about IDDT and celebrates a new era of service innovation.



TIP!

Talk to your technical-assistance consultants (or other source of technical support) about your feelings and thoughts regarding the implementation process. They may have insights and advice from colleagues at other programs who have gone through all five stages of implementation. The insights and advice might help you through this transitional period.



STAGE 4 ACTION

“Structural supports necessary to initiate the program are put in place. These include ensuring the availability of funding streams, human resource strategies, and policy development as well as creating referral mechanisms, reporting frameworks, and outcome expectations.”

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, p16.



Implementing

In this stage, the service team begins to provide stage-wise interventions to clients with co-occurring disorders. Your steering committee monitors the progress of these activities by reviewing the results of fidelity reviews, fidelity action plans, and outcomes reports. In addition, your administrative team monitors the individual and political reactions to change within your organization and community: it maintains ongoing communication with everyone involved with and affected by implementation, resolves potential conflicts, and strives to remove barriers to change.

In this stage, members of your administrative team, service team, and steering committee attend training events that are designed to help them translate IDDT principles into practice. However, these individuals may already be attending training. If this is the case, then already there is momentum. This demonstrates that the stages of implementation and change often overlap and that progression is more cyclical than linear.

Provide stage-wise interventions. Monitor fidelity items, outcomes, and reactions to change.

Are you ready? Your clients are waiting. Positive change is in the future!

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

- | | |
|--|--|
| <p>1 CONDUCT A BASELINE FIDELITY REVIEW</p> <p>2 DEVELOP A BASELINE FIDELITY ACTION PLAN</p> <p>3 DEVELOP STAGE-WISE INTERVENTIONS</p> <p>4 ACQUIRE AND INTEGRATE TRAINING</p> <p>5 ENGAGE IN CLINICAL CONSULTATION</p> | <p>6 PROVIDE STAGE-WISE INTERVENTIONS</p> <p>7 DEVELOP AND MONITOR OUTCOMES</p> <p>8 CONTINUE TO EDUCATE AND TRAIN STAKEHOLDERS</p> <p>9 ADDRESS BARRIERS</p> <p>10 ADDRESS UNINTENDED CONSEQUENCES</p> |
|--|--|

1 CONDUCT A BASELINE FIDELITY REVIEW

The fidelity review (or assessment) provides a formal mechanism for independent evaluation of your IDDT services. It is not an audit or accreditation process. It is strictly a quality-improvement process that provides you with information to make decisions about your next steps. Research demonstrates that IDDT programs which maintain fidelity to the model achieve the best results. Optimally, organizations engage in an external IDDT fidelity review process at least once per year. The fidelity review and fidelity action plan (see action step 2 in adjacent column) create a continuous quality-improvement process—a cycle of planning, implementation, evaluation, and service enhancement.

In Ohio, fidelity reviews are conducted onsite at the organization by a team that has been trained to conduct the reviews. The team often consists of representatives from the Ohio SAMI CCOE, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, and representatives from peer IDDT initiatives throughout the state. The SAMI CCOE does not recommend that organizations perform their own fidelity reviews. The experiences of Ohio organizations have demonstrated that external fidelity reviewers provide an objective perspective that is more helpful for future service enhancements.

Fidelity Scale

The fidelity-review team uses the IDDT Fidelity Scale. It is an evaluation instrument that is designed to measure the degree to which programs administer services according to IDDT's organizational index (12 organizational characteristics) and treatment index (14 treatment characteristics). Obtain the IDDT Fidelity Scale online (see sidebar on page 5).

Interviews

The fidelity-review team conducts interviews with agency and service administrators, direct-service staff, family members, and clients. These discussions elicit information about the effectiveness of the IDDT model and provide information about the facilitators and barriers to successful implementation.

Practice observation

If possible, the fidelity-review team observes team meetings, treatment groups, and individual one-on-one practices with clients to observe the team's application of the model's principles.

Documentation reviews

The assessment team reviews randomly drawn consumer case records to ascertain the quality of documentation of integrated assessment, treatment planning, and service provision. It also reviews agency documents to ascertain the presence of policies and procedures that support implementation of the model.

Fidelity scores

External fidelity reviewers will evaluate all the data that the fidelity-review team collects and will generate fidelity scores for all items outlined in the Fidelity Scale.

Fidelity report

External reviewers or program consultants present recommendations and suggestions for each of the fidelity items and recommendations for next steps in a Fidelity Report then work with your steering committee to create an action plan for improving or maintaining fidelity (see "Assemble a steering committee" on page 18).

2 DEVELOP A BASELINE FIDELITY ACTION PLAN

The Fidelity Action Plan is created by your steering committee in consultation with your technical-assistance organization. The plan addresses all areas of the IDDT scale. It outlines next steps in your journey toward reaching and sustaining high fidelity and improved outcomes. It provides accountability to your internal work team and steering committee, which use the document to compare current activities with stated goals each time it meets. The plan consists of four major components:

- Fidelity scale item
- Person or group responsible
- Action required
- Deadline

3 DEVELOP STAGE-WISE INTERVENTIONS

IDDT emphasizes that recovery occurs incrementally over time through stages of change and treatment. Therefore, for people with co-occurring mental and substance use disorders, big changes like sobriety, symptom management, and an increase in independent living are built upon a series of small, incremental changes in feelings, thoughts, and behavior. IDDT services should be developed and delivered in a culturally appropriate manner. This will further assure the likelihood of successful outcomes.

It is time for your service team members to concentrate on utilizing the stage-wise philosophy in their practices. Keep in mind that this practice transformation will also occur in stages over time. First, your team members will develop the capacity to "stage" clients—that is, to assess accurately their experiences and mental and substance abuse symptoms and to utilize the most appropriate interventions for those symptoms and experiences (see Figure 1 on page 36). Then your team members will develop proficiency with the techniques. Be patient yet persistent. Remember that each person on the team will have a different level of readiness to change (see Tip on page 13). Consistently remind them that research suggests that individuals with co-occurring disorders gain the most confidence with personal change when they are encouraged to experience incremental successes over time. It is also important for the service team to acknowledge clients as they experience those successes.

The fidelity review is not an audit or accreditation process. It is strictly a quality-improvement process.

On the road to achieving improved outcomes, fidelity drives the bus.



Resources

For an overview of stage-wise interventions, see Figure 1 on page 36.

Interventions

High-fidelity IDDT programs offer comprehensive services because the recovery process occurs in the context of daily living. The list of services and interventions below emerges from the treatment characteristics of the IDDT Fidelity Scale (see page 5):

- Assertive community treatment
 - Case management
 - Outreach
 - Secondary interventions for non-responders
- Housing/Residential services
- Medical services (to promote health)
 - Pharmacological treatments
 - Primary health services
- Illness management and recovery
 - Psychoeducation
 - Cognitive behavioral methods for using medication
 - Relapse-prevention services
 - Coping-skills interventions
- Supported employment
- Motivational Interviewing (MI)
- Integrated substance abuse and mental health counseling
- Cognitive Behavioral Therapy (CBT)
- Group interventions
 - Persuasion groups or motivational groups
 - Social-skills training
 - Recreational group activity
 - Active-treatment groups
 - Relapse-prevention groups
 - Family therapy (see family services)
- Family Services
 - Outreach, psychoeducation, consultations
 - Collaborations with NAMI
 - Multiple family groups
 - Behavioral Family Therapy (BFT)
 - Multisystemic Family Therapy (MFT)
- Consumer self-help groups
 - Double Trouble/Dual Recovery Anonymous (DRA)
 - Alcoholics Anonymous (AA)
 - Narcotics Anonymous (NA)
 - Cocaine Anonymous (CA)
 - Depression and Bipolar Support Alliance (DBSA)
 - Schizophrenics Anonymous (SA)
 - Emotions Anonymous (EA)

4 ACQUIRE AND INTEGRATE TRAINING

It is important for all administrators, team leaders, clinical supervisors, and service team members to acquire the knowledge and skills necessary to translate IDDT principles into their practice specialties. For this to happen, your organization should make every effort to create a lifelong-learning environment that makes training an essential part of everyone's professional development. In addition, team leaders and supervisors should model new skills and offer supervision in the context of everyday practice (e.g., in the community, in groups, in individual counseling). This training-in-action approach helps accelerate the integration of training into practice. Here are three key points to remember:

- Training is important.
- Training must continually be applied in the work environment with supervision.

- Training is a waste of time and resources if not supported by the policies and procedures of the organization or if not applied and reinforced in supervision.

Program administrators, team leaders, and supervisors should ensure that the work environment emphasizes the following:

- Exploration and implementation of EBPs
- Experiential learning
- Clinical supervision in the context of everyday practice (i.e., in vivo)
- Attention to the work environment
- Staff support
- Attention to removing barriers for the newly implemented practice
- Attention to cultural appropriateness
- Celebrating successes of clients and staff

Supervision in the community

Team leaders and clinical supervisors observe team members at work in the community to ensure that clients are receiving quality care. They also provide team members with immediate feedback about their strengths, weaknesses, and opportunities for professional growth. For instance, the success of motivational interventions depends upon the skillful use of the self, such as body posture, word choice, tone of voice, timing, and the ability to help clients develop discrepancy between their stated recovery goals and their current thoughts and behaviors. Even the most experienced service providers can benefit from in-vivo supervision. Mastery of new knowledge and skills simply cannot be accomplished as effectively with supervision that occurs solely in an office.

Training topics

Plan to make a wide variety of training topics available to your administrative team, service team, and steering committee. Assemble a menu of trainings that address IDDT service development, team building, supervision, and clinical treatment. Check with your technical-assistance organization (or other source of technical support) about the training it offers. For instance, the Ohio SAMI CCOE offers introductory and advanced training events in community locations for providers interested in IDDT. It also offers intensive onsite training to individual organizations. The onsite training addresses the following topics with no less than 30 contact hours:

- Research and efficacy of IDDT
- Issues in the professional relationship
- Stage-wise treatment
- Engagement skills
- Motivational interviewing (basic and advanced skills)
- Assessment (functional and integrated)
- Treatment planning (stage-related interventions)
- Principles of mental health and substance abuse treatment
- Active treatment (substance use/abuse and mental health)
- Group treatment: principles, stages, skills, types (basic and advanced)
- Medical and health issues
- Family treatment interventions
- Relapse prevention
- Supervision
- Introduction to Cognitive Behavioral Therapy (CBT)

“We now have thousands of experiments across the country which have proven that, in mental health, training is not enough to create change.”

—Robert Drake, MD,
Principal author of the
Integrated Dual
Disorder Treatment
model

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Consultation is provided onsite at organizations, in the community with supervisors and service providers, and via teleconferences.

Train non-IDDT providers in your organization

It is also useful to provide IDDT training to staff members who are not a part of your current IDDT team but demonstrate an interest in and commitment to integrated treatment. This will enhance the sustainability of your current IDDT services, because there will be a pool of qualified individuals to fill team roles that become vacant through attrition, such as retirement, illness, and career changes. Staff turnover is inevitable, so plan accordingly. Develop and maintain a systematic method for training new people when they join your organization or IDDT team (i.e., use training expertise from individuals, technical-assistance organizations, and other sources of technical support). Build your training initiative upon important resources, such as the following:

- Training manuals and videos
- Online training
- Training events (e.g., conferences, workshops)
- Onsite clinical consultation (i.e., grand rounds)

The ongoing training of service providers who are not currently a member of your IDDT team will also prepare your organization for the expansion of its IDDT services in the maintenance stage (see page 28), because there will be a pool of qualified and trained team members from which to recruit.

Train stakeholders

See “Continue to educate and train stakeholders” on page 27.

5 ENGAGE IN CLINICAL CONSULTATION

Your technical-assistance consultants continue to work closely with your organization and IDDT team to transform your administrative and service environments (see page 12). Clinical trainers provide one-on-one and group clinical consultation to team leaders, clinical supervisors, and service providers to help them integrate new knowledge and skills into practice. They provide consultation onsite (at the agency), in the community, and via teleconferences. Consultants will participate in treatment-team meetings as a way to demonstrate new leadership and supervision skills, and they will accompany supervisors and team members during outreach activities with clients to demonstrate clinical skills, such as motivational interviewing. This active approach to consultation is an important way to make training come alive—to make it skill-based and experiential. It supports IDDT team members through the process of translating new knowledge and skills into daily routines.

6 PROVIDE STAGE-WISE INTERVENTIONS

You have already identified specific clients who might benefit from IDDT services (see “Plan to start small” on page 20). Your service team will need to utilize an effective instrument (“staging tool”) to evaluate each client for a stage of treatment that addresses his or her current needs

(see Figure 1 on page 36). Your organization and service team should compare available instruments and choose one that will produce the most accurate assessment of clients served by your organization. To be most effective, staging tools must inform an effective treatment plan. Include each completed staging tool in the front of each treatment plan as a reminder to team members to use it continuously to inform each revision of the plan. Examples of staging instruments include the following:

- SATS (Substance Abuse Treatment Scales)
- URICA (University of Rhode Island Change Assessment)
- SOCRATES (Stages of Change Readiness and Treatment Eagerness Scale)

(See URICA, SAMHSA, and Miller in Sources on page 38.)

7 DEVELOP AND MONITOR OUTCOMES

Outcomes data measure the effectiveness of IDDT services. The data enable everyone to step back from their day-to-day work and ask some important questions, like “How are we doing?” and “Is there something we can do better?” It is essential that organizations invest in a mechanism for collecting, evaluating, and reporting outcomes to everyone involved with IDDT, including the following:

- Clients
- Family members
- Service providers
- Agency administrators
- Community stakeholders
- Policy makers
- Foundations
- Local communities

An investment in an outcomes process will help your organization and community make an informed decision about future investments in IDDT and other EBPs. The Needs Assessment exercise in the contemplation stage of implementation provides baseline data for measuring outcomes over time (see page 10). There are a number of outcomes that your organization should continuously monitor, including the following:

- Individual client
- Family outcomes
- Service provider caseload
- Service team aggregate
- Organization (program)
- Systems

(For more information, see Figure 2 on page 37.)

Evaluate outcomes instruments

A variety of outcomes instruments are available from a number of sources. Choose the tools that meet your needs. Here are a few basic tips to keep in mind when choosing outcomes tools:

- Does the instrument measure the client outcomes, organizational outcomes, and service system outcomes that you need to track?
- Has the instrument been designed and tested for the client population served by IDDT?
- Is the instrument simple enough to use in everyday practice?
- Is the instrument evidence-based and does it contain the core components of a valid research instrument (see “Check it out/Review the literature” on pages 10-11)?

(For more information, see SAMHSA 2003 and SAMHSA 2006 in Sources on page 38.)

8 CONTINUE TO EDUCATE AND TRAIN STAKEHOLDERS

Your service team and administrative team are acquiring training and hands-on experience with IDDT principles and practices. This is a good opportunity to share the new knowledge and skills with community stakeholders and other partners. Take your learning into the community. Visit their organizations and invite them to yours. Also, ask them to attend training sessions, and when appropriate, invite them to consultations with your technical-assistance organization (or other source of technical support). The training of stakeholders (and other individuals) from multiple service systems will help develop a continuity of IDDT philosophies and practices in the community and promote cross-system communication and collaboration. For example, in Ohio, several IDDT programs have invited and included judges, police officers, parole officers, and probation officers in training events as a way to maintain consistent communication with the criminal justice system. Ohio providers have also invited and included instructors from social work departments in local colleges and universities as a way to promote IDDT among the next generation of licensed social workers and certified chemical dependency counselors.

Continue to welcome stakeholders into the implementation process and give them opportunities to contribute their experience, expertise, and resources to the IDDT cause. It will be helpful to publicize the progress and successes of your IDDT program to stakeholders as another way to keep them informed (e.g., quarterly newsletter). Build relationships and service compatibility through constant communication.

9 ADDRESS BARRIERS

In the contemplation stage, you identified some potential barriers to implementation (see “Develop informed consent and consensus” and “Explore concerns” on pages 12 and 13). Now that you are actually implementing IDDT, you will come face-to-face with these and other barriers. You will recognize the barriers when you feel that you have stopped making progress. Remember that the policies and practices of your organization, collaborating organizations, and service systems are among the most common barriers. For example, IDDT provides time-unlimited services. Yet, if your agency has a policy to close a case after 90 days of no contact, this policy will be a barrier to helping clients with long-term recovery issues (e.g., relapse, hospitalization, incarceration, and homelessness). Your steering committee should develop a plan to address and remove implementation barriers. Integrate the committee’s ideas into your Implementation Plan (see page 21).

10 ADDRESS UNINTENDED CONSEQUENCES

There will be anticipated consequences of IDDT implementation (see “Address barriers” section above), and there will also be unanticipated (or unintended) consequences, which can have both negative and positive impacts. For instance, you may see an increased demand for integrated services through traditional and non-traditional sources (e.g., courts, families, and consumers). You may also experience a shift from a silo-like service structure that is defined by grant-funded programs to integrated and collaborative work teams that address the comprehensive needs of consumers. Bring all positive and negative consequences of implementation to your steering committee members for their problem-solving recommendations (see “Assemble a steering committee” on page 18).

Remember that staff members and community stakeholders must adjust to the changes that your organization has made, is in the process of making, and will continue to make. Be strategic about how you address any potential reactions, such as doubt and disbelief in the IDDT model. Timing is important. You may need to be patient. Negativity is sometimes just an initial reaction to change that actually foreshadows an individual’s movement toward positive actions (e.g., a transition from the contemplation stage to the preparation stage of personal change). However, negativity is sometimes a definite heels-in-the-sand resistance that keeps a person firmly rooted in the pre-contemplation stage—the business-as-usual disposition (see page 6). Consider the potential consequences of changing the organizational status quo. It is often difficult to predict how people will react to your promotion of IDDT. It will be helpful to develop a plan to address any potential negative feelings and reactions that staff members may have to your new organizational priorities and evidence-based clinical practice standards. You may need to find allies who can help preserve your IDDT program, especially your collaborations with community stakeholders.

Ask your technical-assistance consultants (or other source of technical support) for advice about managing unintended consequences. They may have helped other IDDT programs deal with similar situations in other communities. They may be able to suggest strategies that will work for you. Service providers and systems have learned many lessons from their implementation of the model and are often willing to share them with organizations who are developing IDDT. These perspectives are an invaluable resource to programs in all stages of implementation.

Fidelity scores measure the process of implementation. Outcomes data measure the effectiveness of services.



TIP! Before you initiate the *Action* stage of implementation, make sure your steering committee and implementation team have identified the outcomes that your organization wants to measure (see Figure 2 on page 37). Also, make sure that your team has outlined the process by which the outcomes will be collected, recorded, analyzed, and reviewed by everyone involved with IDDT implementation.



STAGE 5 MAINTENANCE

“The goal during this stage is the long-term survival and continued effectiveness of the implementation... in the context of a changing world.”

—Dean L. Fixsen, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, p17.



Sustaining

In all the previous stages of implementation, your organization was building a quality-improvement process centered upon the IDDT model. If you have followed and continue to follow the stages and steps outlined in this booklet, you now have a process in place from which to develop IDDT services and to grow and improve continuously.

In this stage of IDDT implementation, your organization will sustain its quality-improvement process by continuing to integrate the principles, practices, and structure of IDDT into the service culture of the entire organization and within the community. Therefore, the strategies described on the following pages are intended to help your organization sustain all the advances it has made thus far. For instance, your implementation team and steering committee will continue to focus on fidelity and outcomes as your organization expands its IDDT services by adding more service teams, by serving more clients, and by utilizing integrated treatment principles in

other services that it provides. In addition, your implementation team and steering committee will prepare for periods of change and transition that may result from the following:

- Service expansion
- Increased referrals and demands for services
- Staff turnover
- Loss of IDDT champions
- Loss of steering committee members
- Leadership changes at your organization and community stakeholder organizations
- Leadership changes at state and county authorities
- Changes in public policies
- Changes in funding streams
- Addition or attrition of community stakeholders
- Implementation of additional EBPs and other service innovations

(For more information, see Torrey in Sources on page 38.)

Sustain your quality improvement process and continue to innovate.

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

- | | |
|------------------------------|---|
| 1 MAINTAIN OVERSIGHT | 5 PROVIDE ONGOING TRAINING |
| 2 MONITOR FIDELITY | 6 ENGAGE IN ONGOING CONSULTATION |
| 3 MONITOR OUTCOMES | 7 EXPAND IDDT SERVICES |
| 4 NETWORK WITH OTHERS | 8 TRANSFORM THE ORGANIZATIONAL CULTURE |

1 MAINTAIN OVERSIGHT

At this point, your IDDT service is experiencing fewer system barriers to implementation, so your steering committee meets less frequently. However, the internal work team (which is part of the steering committee) continues to provide oversight of fidelity reviews and fidelity action plans (see “Assemble a steering committee” on page 18). The work team also provides continuity of leadership during periods of administrative change.

Although the steering committee itself meets less frequently, the internal work team of your organization continues to meet monthly or quarterly. The work team and steering committee oversee a number of activities related to IDDT’s continuous quality-improvement process. They perform the following tasks:

- Review annual fidelity reports
- Revise the fidelity action plan
- Track desired outcomes
- Review outcome reports
- Review and recommend enhancements to administrative policies and practices
- Identify and minimize organizational barriers and systems barriers to fidelity and improved outcomes
- Plan for continued funding

2 MONITOR FIDELITY

Without consistent and regularly scheduled fidelity reviews, reports, and action plans, your program may run the risk of drifting away from the principles of IDDT and into non-evidence-based practices. For example, if your organization experiences a budget crisis and decides to cut case managers from the IDDT team to save money, the ratio of clients to case managers will increase beyond the 15:1 or 20:1 suggested by the research. This will compromise quality and outcomes. In addition, if another program within your agency or community wants to “buy” or “borrow” some time from the team nurse, this may compromise his or her ability to give IDDT clients the attention they need and deserve. When your program achieves high fidelity, you should continue to pay attention to it. Remember that new programs typically engage in a fidelity review process every six months. Established programs with high fidelity continue to engage in annual fidelity reviews.

(For more information, see these sections: “Conduct a baseline fidelity review” and “Develop a baseline fidelity action plan” on page 24.)

3 MONITOR OUTCOMES

Pay close attention to outcomes data at the same time you pay attention to fidelity. A drop in outcomes may indicate a drop in fidelity. Likewise, an increase in outcomes may indicate an improvement in fidelity. Invest in a mechanism for collecting, evaluating, and reporting outcomes to everyone involved with IDDT, including

service providers, clients, family members, community stakeholders, policy makers, foundations, and other departments within your organization. Your openness and honesty will inspire hope about improvements and help from others if outcomes begin to slip. There are a number of outcomes categories that your program should continuously monitor. They include the following:

- Client
- Family
- Organization (program)
- System

(For more information, see the “Develop and monitor outcomes” section on page 26.)

4 NETWORK WITH OTHERS

It is important for program administrators, team leaders, and service providers to maintain the formal and informal networks of professional peer support that they developed during the contemplation, preparation, and action stages of implementation. These networks provide a forum for everyone to share the lessons they are learning about implementation. This form of dissemination helps new and existing IDDT services avoid common pitfalls, overcome barriers, and capitalize on strategies that work.

While it is important to maintain your current networks, it is also important to expand them. Develop relationships with colleagues in other systems and disciplines as a way to promote IDDT’s principles and practices and as a way to integrate the knowledge and practice of your peers into your work. For instance, there is a growing interest among law enforcement and criminal justice professionals for crisis intervention training (CIT) to learn how to intervene more effectively with people who have co-occurring disorders. Use the training events as an opportunity to engage in dialogue with your peers from other professional disciplines and/or service systems. Stay open to learning something new from them: the two-way exchange of information may serve as a foundation for future collaborations.

Your organization or a technical-assistance organization may sponsor professional peer networks, such as the following:

- Monthly team-leader consultation (onsite or teleconference)
- Family program-development consultation (teleconference)
- Regional networks
- Online networks (e.g., message boards, listserves)

(Participate in a free online implementation network: www.ohiosamcocoe.case.edu/training/messageboard_fr.html)

The steering committee oversees the quality-improvement process.

5 PROVIDE ONGOING TRAINING

Training is an integral part of your organization's quality-improvement process. It equips administrators, clinical supervisors, team leaders, and service providers with the knowledge and skills they need to improve their practices continuously. In the preparation stage of implementation, you identified and recruited team members who are committed to lifelong learning. Therefore, it is important to maintain a work environment that supports lifelong learning; you should provide ongoing advanced and updated training in core components of the IDDT model to support the professional development of your team members.

Promote cross-training

With incremental change, your organization builds capacity to serve all people with co-occurring disorders in your community. In doing so, your team members will likely interact with more service providers from other sectors of the community and other professional disciplines. "Cross-training" helps integrate multidisciplinary knowledge, which makes services more integrated and comprehensive. One way to promote cross-training within your organization is to include an overview of integrated treatment as part of the orientation process for *all* new employees. It is important to establish a training and implementation plan for co-occurring disorders throughout your organization. This will prepare a roster of qualified individuals to fill team roles that will become available when your IDDT services expand and when positions become available through staff attrition, such as retirement, illness, and career changes.

Remember to continue to extend training opportunities to individuals at organizations in other service systems. The training will help maintain a continuity of IDDT philosophies and practices across service systems, as well as maintain cross-system communication and collaboration.

(For more information, see the "Acquire and integrate training" section on page 25. Also see the "Continue to educate and train stakeholders" section on page 27.)

6 ENGAGE IN ONGOING CONSULTATION

Stay connected with peers at other organizations who are implementing IDDT, and stay connected to consultants and trainers at technical-assistance organizations (or other sources of technical support). These people will help you navigate transitional periods and incorporate lessons learned at other high-fidelity IDDT programs. Many technical-assistance organizations provide organizational

consultation to address the administration of IDDT programs and clinical consultation to address the quality of service delivery.

(For more information, see the "Engage technical assistance" section on page 12.)

7 EXPAND IDDT SERVICES

In the contemplation and preparation stages of implementation, you identified the total number of clients in your local mental health and substance abuse systems who would benefit from IDDT services. However, you most likely have been working with a subset of this group as a way to facilitate manageable change in your organization and community. For instance, you may have identified 1,000 eligible clients but chose to assemble one multidisciplinary team to work with 50 clients. As this team approaches high fidelity and improves outcomes, it is time to begin the expansion of integrated treatment activities: for example, additional service teams now begin to work with additional client groups. It is important that your steering committee, administrative team, and direct-service team ask this question: "How do we reach the greatest number of eligible clients?"

8 TRANSFORM THE ORGANIZATIONAL CULTURE

As your organization adds more IDDT teams and clients and cross-trains more service providers, your entire organization continues to change. So does the service environment in your community. An integrated approach becomes the cultural norm.

Accommodate innovations

Once IDDT is completely implemented with all targeted client groups and is achieving high fidelity and good outcomes, it is time to test those service innovations that seem like "good ideas" but are not a part of the evidence-based practices research. For instance, many consumers report experiences of trauma. As a result, service providers are exploring how they might include trauma services as part of IDDT. Inform your steering committee if you decide to experiment with an innovation like this and ask it to keep a close eye on fidelity scores and outcomes. If the data show a drop in performance, explore and assess the reasons. If the data show a rise in performance, spread the news to other high-fidelity programs in your professional peer network. They might be interested in trying to duplicate the favorable results.

continued on next page

Serve more clients incrementally as a way to manage organizational change.

Implement additional EBPs

The knowledge and experience that you accumulate from implementing IDDT with high fidelity and positive outcomes can be transferred to the implementation of additional EBPs. It is time to start the implementation process again. Return to your comprehensive Needs Assessment, which you conducted in the contemplation stage of implementation. Which client group on the list demonstrates the next highest need? From which services will they most benefit? Raise these important questions with your IDDT steering committee members, then begin the process of identifying potential committee members for the next EBP. You might find some of your best candidates on the IDDT committee.

(For more information, see the “Develop awareness of available options” section on page 10.)

Celebrate and evaluate successes

The pace of work in most service organizations is very fast. It seems that service providers and administrators alike are constantly “moving on” to the next opportunity, the next challenge. While working at a fast pace, there is often little time to notice, celebrate, and evaluate your successes. However, these activities are important, because they provide opportunities for organizational self-reflection and, therefore, quality improvement.

Take time to celebrate and evaluate successes together, so everyone becomes conscious of the organizational processes that produce positive outcomes. Be sure to include direct-service providers, administrators, steering committee members, community stakeholders, consumers, and family members in the celebration and evaluation and share the results openly. The process of organizational self-reflection will provide energy for future innovations.

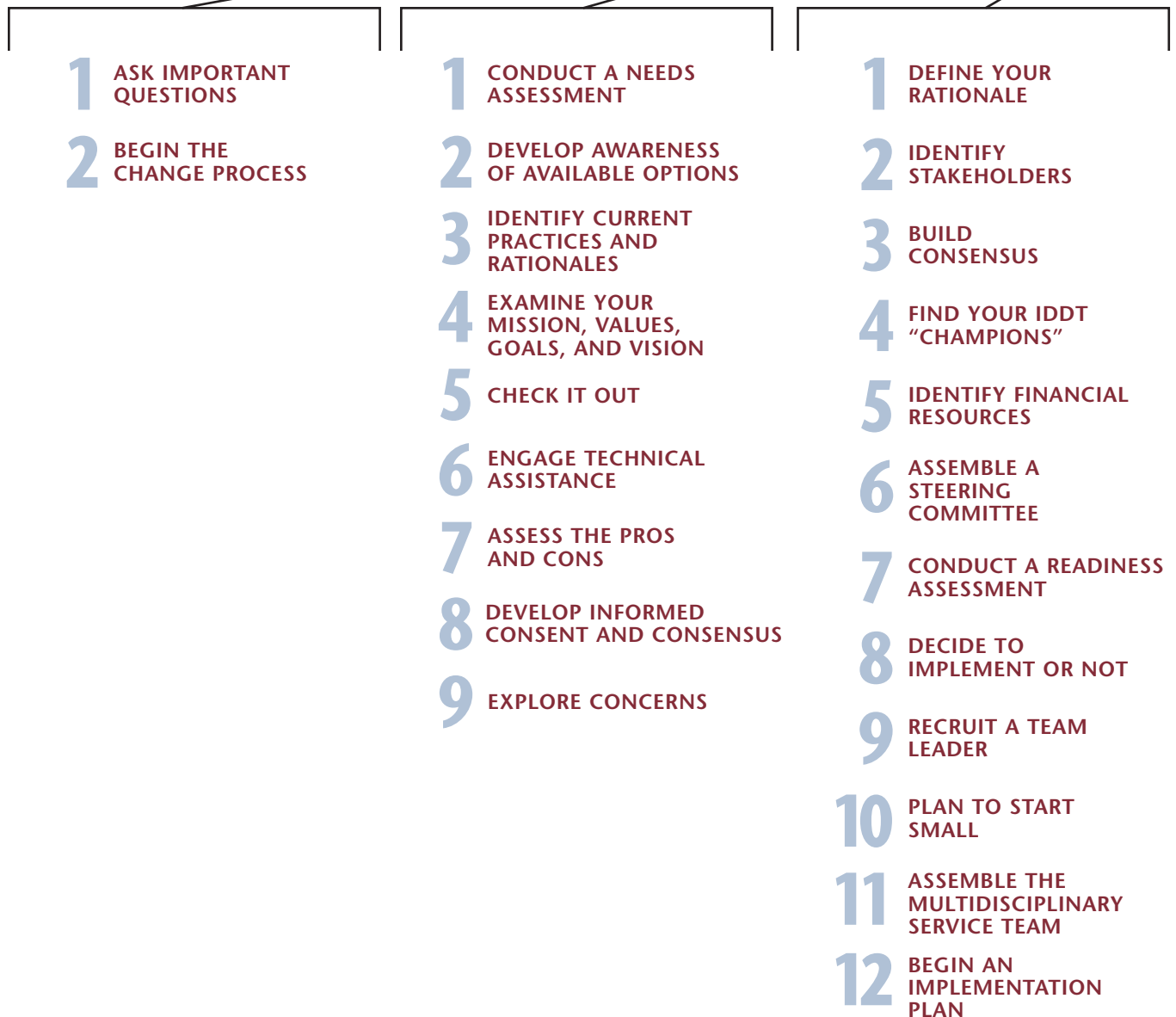


Maintain your momentum as you implement the next EBP. Think about the future. There are service systems, community stakeholders, and clients and their families who will benefit from the positive outcomes of other EBPs. Invite them to contribute their knowledge, their experiences, and their hope to the next phase of the journey.



IMPLEMENTING IDDT: AT-A

STAGE	1	2	3
Stages of change	Pre-Contemplation	Contemplation	Preparation
Stages of implementation	Unaware or uninterested	Consensus building	Motivating



-GLANCE



4	5
Action	Maintenance
Implementing	Sustaining

- | | |
|---|--|
| <ol style="list-style-type: none">1 CONDUCT A BASELINE FIDELITY REVIEW2 DEVELOP A BASELINE FIDELITY ACTION PLAN3 DEVELOP STAGE-WISE INTERVENTIONS4 ACQUIRE AND INTEGRATE TRAINING5 ENGAGE IN CLINICAL CONSULTATION6 PROVIDE STAGE-WISE INTERVENTIONS7 DEVELOP AND MONITOR OUTCOMES8 CONTINUE TO EDUCATE AND TRAIN STAKEHOLDERS9 ADDRESS BARRIERS10 ADDRESS UNINTENDED CONSEQUENCES | <ol style="list-style-type: none">1 MAINTAIN OVERSIGHT2 MONITOR FIDELITY3 MONITOR OUTCOMES4 NETWORK WITH OTHERS5 PROVIDE ONGOING TRAINING6 ENGAGE IN ONGOING CONSULTATION7 EXPAND IDDT SERVICES8 TRANSFORM THE ORGANIZATIONAL CULTURE |
|---|--|

FIGURE 1

Stages of Personal Change	Stages of IDDT Treatment	Clinical Focus
Pre-Contemplation	Engagement	<p>Outreach</p> <ul style="list-style-type: none"> • Provide outreach in community-based settings <p>Trusting Relationship</p> <ul style="list-style-type: none"> • Gain permission from consumers to share in their process of change <ul style="list-style-type: none"> • Ask consumers what is important to them • Listen to and respect their priorities • Get to know the person for who they are <p>Practical Support</p> <ul style="list-style-type: none"> • Provide support for daily living (i.e., food, clothing, housing, medicine, safety, crisis intervention) <p>Assessment</p> <ul style="list-style-type: none"> • Assess continuously for consumers' personal histories, goals, and readiness-to-change
Contemplation and Preparation	Persuasion	<p>Motivational Interventions</p> <ul style="list-style-type: none"> • Commit yourself to understanding consumers' goals • Help consumers understand the pros and cons of personal change • Help consumers establish the discrepancy between their goals, their substance use, and their lifestyles (e.g., thoughts, feelings, behavior) • Help consumers begin to reduce substance use and take medications regularly • Help consumers recognize and take pride in their own strengths and successes <p>Ambivalence is Normal</p> <ul style="list-style-type: none"> • Assure consumers that ambivalence to change is a normal human response (change may occur slowly over time) <p>Pay-Off Matrix</p> <ul style="list-style-type: none"> • Use a pay-off matrix to help consumers tip decisions away from ambivalence and toward positive action <p>Education</p> <ul style="list-style-type: none"> • Teach consumers about alcohol, drugs, mental illness, and activities that promote health and wellness • Offer skills-training opportunities • Reach out and provide support to families
Action	Active Treatment	<p>Skill Building</p> <ul style="list-style-type: none"> • Teach illness management skills for both disorders (e.g, refusal skills, managing triggers and cravings, recognizing symptom onset, communication skills, etc.) <p>Social Support</p> <ul style="list-style-type: none"> • Encourage positive peer supports (e.g., self-help groups) <p>Cognitive Behavioral Interventions</p> <ul style="list-style-type: none"> • Assist consumers with transforming negative thoughts and behaviors into coping skills for both disorders
Maintenance	Relapse Prevention	<p>Planning</p> <ul style="list-style-type: none"> • Develop a relapse-prevention plan • Support consumers as they maintain lifestyle changes learned in active treatment <p>Recovery Lifestyle</p> <ul style="list-style-type: none"> • Help consumers set new goals for enhancing their quality of life <p>Social Support</p> <ul style="list-style-type: none"> • Reduce the frequency, intensity, and duration of relapses with positive peer relationships and supportive clinical relationships



Resources

This table is also available as a 24"x36" poster. Consult this resource from the IDDT Library and Links database:
 IDDT Poster: Stages of Change & Treatment (2004).
www.ohiosamimccoe.case.edu/library/emailresource.cfm?resourceid=85

FIGURE 2

OUTCOMES DATA	Individual client outcomes	Family outcomes	Organization/program outcomes	Systems outcomes
Quality of life	X	X		
Psychiatric symptoms	X			
Alcohol and other substance use	X	X		
Abstinence rates	X		X	X
Progress through stages of substance abuse treatment	X		X	X
Educational status	X			
Family and peer relationships	X	X		
Criminal justice system involvement (arrest and incarceration)	X		X	X
Satisfaction with services	X	X	X	X
Employment (hours worked in competitive employment)	X		X	X
Housing/Independent living status	X		X	X
Psychiatric hospitalization rates	X		X	X
Improved problem-solving skills	X	X		
Reduced burden and stress		X		
Greater awareness about mental illness and substance use disorders	X	X		
Service utilization (e.g., episodes of care, case management, treatment groups, individual services)	X		X	X
Crisis/emergency service utilization	X		X	X
Bed days/detox or subacute detox days	X		X	X
Cost-effectiveness			X	X



Resources

Consult the online Library and Links database and select “IDDT” then “fidelity and outcomes”:
www.ohiosamcocoe.case.edu/library/

Also consult this resource from the Library and Links database:

SAMHSA (Substance Abuse and Mental Health Services Administration) (2006).

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SOURCES & RESOURCES



Hyperlinks to many of these resources may be obtained from our free online IDDT Library and Links database:
www.ohiosamicroe.case.edu/library

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- For “Introduction/IDDT Fidelity Scale” (on page 5), consult the “Integrated Dual Disorder Treatment Fidelity Scale” section of this SAMHSA resource.
- For “Stage 2: Contemplation/Check it out/Review the literature” (on pages 10-11), consult the “Monitoring Client Outcomes” section of this SAMHSA resource.
- For “Stage 4: Action/Provide stage-wise interventions” (on page 26), consult page 29 of the “IDDT Workbook” section in this SAMHSA resource.
- For “Stage 4: Action/Develop and monitor outcomes/Evaluate outcomes instruments (on page 26) consult the “Monitoring Client Outcomes” section of this SAMHSA resource.

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For more resources to help implement and sustain the IDDT model, consult our free online IDDT Library and Links database.



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For information about writers, editors, and financial support for this publication, see back panel.

Additional contributors to the production of this booklet include the individuals listed to the right. The Ohio SAMI CCOE wishes to thank everyone who contributed their time, insight, and suggestions for enhancements. Most of all, we wish to thank you for sharing your talent and commitment to excellence.

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OHIO SAMI CCOE

ABOUT US

The Ohio SAMI CCOE is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people with mental and substance use disorders. The SAMI CCOE helps service systems, organizations, and providers implement and sustain the Integrated Dual Disorder Treatment (IDDT) model, maintain fidelity to the model, and develop collaborations within local communities that enhance the quality of life for consumers and their families. The SAMI CCOE provides these services:

- Service systems consultation
- Training
- Program consultation
- Research and evaluation
- Clinical consultation



EVIDENCE-BASED

EBPs are service models that research has demonstrated to generate improved consumer outcomes, program outcomes, and systems outcomes. Research shows that organizations which maintain fidelity to the original design of each EBP achieve and sustain the best outcomes.

TRAINING & CONSULTING

Our consultants and trainers are experienced administrators, service providers, and researchers who offer personal attention and customized training and consultation throughout the implementation process. We understand that every service system and organization exists within a unique social, political, and economic context. Therefore, we work closely with you to adapt IDDT to the unique culture of your community and, at the same time, to maintain fidelity to the model.

This booklet is part of an evolving training and consultation process from the Ohio SAMI CCOE. It is written for policy makers, administrators, and service providers who want to implement and sustain the IDDT model.

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Build trust
Improve outcomes
Promote recovery



Resources

To obtain additional printed copies of this booklet, contact our office or visit our web site for an order form.

Additional resources are listed on page 38.



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