

**Integrating Multiple Evidence-Based Practices in a  
Public Mental Health Organization:  
*An Implementation Field Guide for  
Project Managers and  
Clinical Supervisors***

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*We wish to acknowledge the contributions of*  
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*David L. Neal, LMSW, Emeritus Professor, UM Department of Psychiatry;*  
*as well as the contributions of other CSTS and WCHO*  
*Administrators, Case Managers and Clinicians.*



**Funded by a**  
**State of Michigan Department of Community Health (MDCH) Grant**  
**awarded to the University of Michigan, Department of Psychiatry**

## Preface

This manual has been developed for Project Managers and Clinical Supervisors who have the responsibility of implementing evidence-based practices (EBPs) in their clinics and mental health service-provider settings. It highlights the challenges that Project Managers and Clinical Supervisors face in the implementation and sustainability phases of delivering services based on more than one evidence-based practice. The information provided in this manual captures the experiences of Project Managers and Clinical Supervisors in one large community mental health service system that implemented three evidence-based practices over a five-year period of time. The three practices are Family Psychoeducation (FPE), Integrated Dual Disorders Treatment (IDDT) and Assertive Community Treatment (ACT). The FPE and IDDT practices were implemented at the same time, while the ACT practice was already in place but had not been monitored for high-fidelity model adherence for a number of years. All three practices are among those endorsed by the United States federal government's Substance Abuse and Mental Health Services Administration (SAMHSA), and described in detail at [www.mentalhealthpractices.org](http://www.mentalhealthpractices.org).

The primary goal of this manual is to provide a practical guide for Project Managers and Clinical Supervisors to use when integrating more than one evidence-based practice within the same organization. Most evidence-based practices have manuals and toolkits that explain the steps needed to deliver that single evidence-based practice with fidelity (e.g. [www.mentalhealthpractices.org](http://www.mentalhealthpractices.org)). These toolkits are of significant assistance when implementing one practice, but do not address scenarios in which organizations desire to implement and integrate multiple evidence-based practices. This manual is intended to fill this gap for Project Managers and Clinical Supervisors by sharing lessons learned while integrating multiple evidence-based practices in one organization.

The manual breaks the implementation process into four distinct phases.

**Phase One: Preparing for Action**

**Phase Two: Developing Work Plans**

**Phase Three: Implementing the Evidence-Based Practices**

**Phase Four: Sustaining the Evidence-Based Practices**

These phases build on each other and may appear linear, but due to the complex nature of this work and the differences between organizations, steps along the way will necessarily be repeated. Each phase includes cross-cutting themes such as ***building consensus, assessing barriers, reviewing and modifying work plans***, and the ***continued need for recruiting champions***.

To make the information as accessible as possible, the authors are utilizing the convention of denoting different types of information with several different icons and “call out” titles, as follows:



**Tip** = A practical suggestion (e.g. a pitfall to avoid).



**From the Field** = Examples from our organization, “snapshots” of experiences we’ve had (positive or negative) that have yielded useful lessons.



**Resources** = Where to get more information on a topic.

This Implementation Field Guide has evolved from the use of several SAMHSA EBP toolkits, which are referenced throughout. It is our hope that this work will assist you and your organization in bringing these valuable services to the individuals who need them so much.

*Jeff Capobianco - Steve Wiland - Jim Svensson - Mary Ruffolo - Caroline Fricker*

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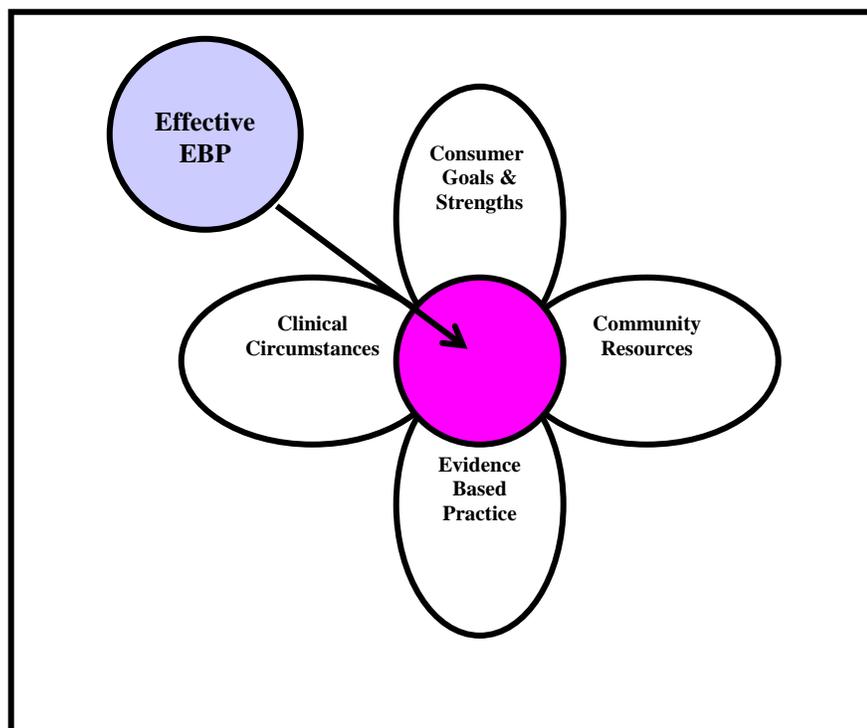
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## 1.0 Implementing and Integrating Evidence-Based Practices: An Overview

There is increasing pressure for community-based mental health organizations to deliver evidence-based mental health services that improve outcomes for consumers and their families. Several recent national reports conducted by the Department of Health and Human Services, the National Institute of Mental Health, and the President's New Freedom Commission call for major changes in the delivery of mental health services. These reports promote the use of evidence-based practices to produce valued outcomes for consumers and families (Panzano & Herman, 2005).

The Institute of Medicine (IOM) defines evidence-based practice (EBP) as “the integration of the **best research evidence** with **clinical expertise** and **patient values**” (IOM, 2001), with all three of these elements considered critical. **Best research evidence** refers to that which is clinically relevant and client-centered. **Clinical expertise** means the ability to use past professional experience to quickly identify clients' health status and unique needs. **Client values** address the need to integrate in clinical decisions the preferences, concerns, and priorities of the service consumer.



The recent Institute of Medicine (IOM) report, ***Crossing the Quality Chasm: A New Health System in the 21<sup>st</sup> Century*** (2001), highlights priority conditions for evidence-based practice in health care. These priority conditions include: ongoing analysis and synthesis of the medical evidence, delineation of specific practice guidelines, identification of best practices, widespread communication of evidence and guidelines, development of decision-support tools to assist clinicians and patients in applying the evidence, and the establishment of goals for improvement in care (IOM, 2001).

For mental health professionals, the use of evidence-based practices maximizes the likelihood of achieving the outcomes consumers and families hope for, while minimizing any potential for harm. Implementing and integrating more than one evidence-based practice in an organization provides mental health professionals with a range of intervention options that support consumer recovery efforts.

Efforts over the past 20 years to promote evidence-based practices, such as the evolution of program evaluation methods and encouraging clinicians to read, synthesize and apply intervention research in practice, have often resulted in significant resistance from mental health professionals (Kirk, 1999). Because evidence-based interventions have often addressed the “average” consumer experiencing a problem condition, many mental health professionals report not finding the information helpful since the research does not necessarily address what intervention is best for the unique consumer at hand. The development of practice guidelines and toolkits for specific interventions has been viewed as an important factor in addressing these concerns and helping mental health professionals to move forward with utilizing evidence-based practices.

## 2.0 Preparing for Action

The first step in preparing for action is to “begin at the beginning.” Some organizations are well versed in the definition and use of evidence-based practice, and are integrating an additional practice or practices with established programs. Other organizations are implementing one or more practices for the first time, highly motivated by the promise of greater service efficacy. Still others are experiencing demands to implement their first evidence-based practices from external sources such as funders, consumer advocacy groups or state government, and are beginning the process of implementation only reluctantly. Whatever your position, the following steps will support you and your staff in gathering critical information about where your organization is, and where you would like it to be, as it relates to EBPs.



### ***Tip:***

*In response to pressure from internal (administration) or external forces (funders), avoid the temptation to:*

- *immediately send staff off to EBP training*
- *quickly form an ad hoc steering committee*
- *assign a champion to “just do it”*

*INSTEAD, begin with a thoughtful, clearly delineated, and well-resourced plan of action approved by senior management.*



***From the Field:*** *Genuinely excited about a new practice she had learned about at a conference, our Executive Director returned eager to “get it started here”. Within one year of her return from this conference we had several staff trained in the model yet no clear plan about how it was to be implemented. By the time a champion was identified, and a plan for implementation completed, several of the originally trained staff had left while others needed to be retrained. Due to this initial rush to train we ended up needing to retrain staff at a considerable cost, both to our bottom line and to staff morale.*

## **2.1 Define the Practices You Will Be Implementing**

The first step in Phase One is to define what EBPs are, and what they are not. There are many definitions of evidence-based practice, and clarity is essential when defining and choosing which to implement. Which definition and practices are chosen will have direct bearing on how future practices will (or will not) be embraced, and therefore, on how scarce funding resources will be allocated. Additionally, a clear definition of what EBPs are (and are not) will allow for the best evaluation of requests by stakeholders to start new practices. Without a clear definition of EBPs, it is difficult to compare one practice to another, thus making the choice of what and why to implement potentially confusing.

A helpful example of how an EBP may be defined has come from the *Iowa Practice Improvement Collaborative*. They developed a plan that established criteria for selecting evidence-based practices used in delivering substance abuse services to their state. For this group, the evidence-based practice needed to meet the following criteria:

- 1. At least one randomized clinical trial has shown this practice to be effective.**
- 2. The practice has demonstrated effectiveness in several replicated research studies using different samples, at least one of which is comparable to the treatment population of the newly implementing region or organization.**
- 3. The practice either targets behaviors or shows good effect on behaviors that are generally accepted outcomes.**
- 4. The practice can logistically be applied in newly implementing regions, and in rural and low population density areas.**
- 5. The practice is feasible: it can be used in a group format, is attractive to third-party payers, is of low cost, and training is available.**

6. The practice is manualized or sufficiently operationalized for staff use. Its key components are clearly laid out.
7. The practice is well accepted by providers and clients.
8. The practice is based on clear and well-articulated theory.
9. The practice has associated methods of ensuring fidelity.
10. The practice can be evaluated.
11. The practice shows good retention rates for clients.
12. The practice addresses cultural diversity and different populations.
13. The practice can be used by staff with a wide diversity of backgrounds and training.

*(Iowa Practice Improvement Collaborative, 2003, 4-8)*

In summary, thoughtfully defining the EBPs prior to implementation will provide a better foundation upon which your organization can build a program. It is important to have this definition for staff and consumers to use when talking about different practices and services. Consumers and staff must understand what EBPs are, and are not, so they can make educated choices about treatment services. A clear definition will also provide the standard for building consensus regarding choice of future practices.



### **Resources:**

Stephen Leff from the **Human Services Research Institute** has identified the following concerns regarding evidence-based practices: (See also [http://download.ncadi.samhsa.gov/ken/pdf/SMA01-3938/MHUS02\\_Chapter\\_17.pdf](http://download.ncadi.samhsa.gov/ken/pdf/SMA01-3938/MHUS02_Chapter_17.pdf))

#### **“The Democratic Concern”**

*Evidence-based practices could emphasize the views of scientific elites and funders that pay for their investigations, and may ignore the views of various citizen groups in a manner that is in discord with self-determination.*

#### **“Traditional Science is Limited”**

*Science is a method not always appropriate for assessing or investigating recovery techniques. Qualitative research*

*techniques are sometimes better at capturing what experimental methods cannot.*

***“Technical Problems In Identifying Evidence-Based Practices”***

*The method for validating an evidence-based practice is not without problems. The use of meta-analytic techniques yields an overall average effect for a group of studies. Meta-analytic techniques cannot, however, tease out which independent variable had the greatest effect.*

***“Over-statement”***

*At this time it is not known what components of an evidence-based practice are effective or ineffective. This point dovetails with the last one. Not only are meta-analytic techniques ill fit to identifying “key ingredients” of an intervention. The “file drawer problem” also exists (Kellinger & Lee, 2000). Some estimates show that for every 345 published articles there are 65,123 unpublished articles (Rosenthal & Rubin, 1978). The reason is most journal editors only publish studies with significant results. This could lead to overstating the positive effects of a practice.*

***“Untested Will Be Interpreted as Equivalent to Ineffective”***

*The danger that if an intervention or technique is not deemed an “evidence based practice”, or even a best practice, that it will not be funded or worse be seen as ineffective or dangerous.*

***“Knowing is Not Equivalent to Practicing”***

*The implementation of an EBP cannot occur in a vacuum. Therefore when implementing an EBP, unplanned variables will have to be dealt with. These unplanned variables are typically a community’s unique needs and strengths. The process of implementation requires consensus among all community stakeholders. In addition, objective expert consultation is required to prevent the unique community implementation challenges from eroding fidelity to the EBP model.*

## **2.2 Identify Champions**

Implementing new evidence-based practices will require changes in current organizational practices and policies, as well as additional resources for providing training and supervision for staff. A recent literature review of implementation

guidelines showed that almost half the factors that contribute to success relate to an organization's capability for planned change (Solberg, 2000). The review indicated that within an organization there needs to be a commitment to change on the part of leadership, enthusiastic staff who volunteer to take on new challenges (e.g., "champions"), resources available for the evidence-based interventions, and the presence of monitoring and improvement systems (e.g., quality improvement) within the organization.

The importance of leadership championing this significant change cannot be overemphasized. Without the enthusiasm of the executive director and any associated board, implementation momentum and the creativity often required to find funding can be lost. Implementing EBPs must be tied to the organization's strategic plan and the budget supporting it. In many respects, the initial impetus to implement one or more evidence-based practices may be perceived as an "unfunded mandate," a perception that can threaten the success of implementation. Although it is good to project a vision of greater cost-effectiveness after one or more EBP has been well-implemented, the initial reality may be that there is "no new money" available within your organization to allocate for the start-up of new or different services. Difficult decisions may need to be made around shifting services, staff, or other resources in support of EBP implementation. This can only occur with administrative and board approval that is consistent with the strategic planning of the organization.



***Tip:***

*Grant funding possibilities should be aggressively explored and pursued, as this is one of a few available options for bringing in "new money" to support some of the start-up costs of EBP implementation. If your organization doesn't have experience writing grants, it might be worth exploring partnering with a local university or nonprofit organization to collaborate. Don't forget to check with your State mental health authority for available block grant funding in support of evidence-based practices.*



***From the Field:*** *One other source of “new money” pursued by our CMH organization involved becoming licensed within our State Substance Abuse Treatment infrastructure as an Addictions Treatment provider. Once this additional level of licensing was in place, our organization was positioned to bill for IDDT services against substance abuse treatment funding sources, in addition to the already established mental health treatment funding streams.*

## **2.3 Assign the Work Group**

Once organization leadership is in agreement on the definition and selection of worthwhile EBPs, a next step is to assign work groups. Made up of key stakeholders, these groups begin the process of developing detailed project work plans that will carry your organization into sustainable practices.

The process begins by developing a charge for the work groups. The charge should be heavily contributed to, or even entirely penned by senior management, and be unambiguous. The charge is one or two sentences that clearly state the purpose of the work groups. From the charge the work groups should have a clear picture of the outcomes they will strive to produce. For example: *“Define and implement two evidence-based practices with fidelity in three years.”* The charge must be generated with buy-in and informed sign-off by senior management, and have the following elements:

- A clear link to the organization’s vision, values, mission and strategic plan goal areas
- A defined and measurable outcome
- A timeline for completion
- A budget
- An assigned leader or committee responsible for the project

- Key stakeholder involvement (i.e. management, frontline / clinical staff, consumers, family members, and key community leaders / advocates)

Most organizations have a Quality Improvement Committee, Performance Improvement Committee, or Clinical Care Committee who are charged by the senior management team with projects. Follow the process your organization uses to start new programs, projects or practices, and make sure the above components are included. If your organization does not have a formal process for rolling out new practices, then borrow from one of the numerous resources that explain how to do project management, or if possible, bring in an outside consultant to assist in the development of the project plan.



### **Resources:**

*The **Community Mental Health Partnership of Southeastern Michigan Policy and Procedure for Approval and Implementation of New Programs** is a guide for staff to follow when implementing a new practice or program. The document is comprehensive, and includes questionnaires to help staff evaluate why and how the program is implemented. [See APPENDIX A]*

## **2.4 Involve Leadership and Continue Identifying Champions**

As previously discussed, leadership involvement is critical, especially in the beginning steps. So, too, are the roles of the champions. The champions are staff who are willing to take lead roles in the start-up of the practices. Champions can come from management or direct service positions, and do not need to be work group leaders. The role of the champions can be looked at from two perspectives, “**purveyor**” or “**implementer.**” The functional descriptions of “purveyor” and “implementer” put forth by the National Implementation Research Network (NIRN) at the University of South Florida are helpful to consider (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). “Purveyors” are described as the individuals who actively work to put a new practice into

place within the infrastructure and service array of a provider organization, while “implementers” are those staff who begin to provide the new services to consumers. This is an important distinction, as individuals with purveyor expertise may lack implementer expertise, while expert implementers may lack the experience, skill set, or knowledge base to also serve as effective purveyors. In our experience mental health agencies often have staff who are interested in implementing new practices. The skill sets associated with the purveyor role, however, (e.g. project management) are perhaps more difficult to find, as they are not inherent in the existing clinical training programs that educate the majority of human services agency employees. Whether an organization can identify internal personnel to cover the “purveyor” and “implementer” bases, or whether a purveyor external to the organization needs to be brought in to work collaboratively with internal implementers, it is important that BOTH functions be well-served. The organization needs “purveyor champions” who can help create and bring a work plan into place, as well as “implementer champions,” skilled clinicians with expertise in the practice area who can assist staff in implementing the clinical components of the practice.

Champions are typically visible within the organization, if looked for. They are the staff who are passionate about the proposed practice, respected by their peers, eager to improve services, and willing to do what it takes to make a positive change in services for consumers and staff alike. This combination allows them to more easily impact opinion and create momentum, which ultimately leads to change.



***Tip:***

*If / As you are implementing more than one practice, make sure to have a champion for each practice area.*



***From the Field:*** While our organization was implementing FPE, a clinician who worked closely with the local NAMI chapter showed enthusiasm for the model and started asking questions about when and how the model would be implemented. That

clinician's Supervisor noticed this enthusiasm and discussed the possibility of the clinician taking a leadership role in the practice implementation. In a matter of a week the clinician's work plan was changed to allow for the time to collaborate with administrators to develop an implementation plan.



**Tip:**

***If a champion for a specific EBP is not obvious within your organization, talk with Supervisors and staff about who has the most expertise, experience and/or passion for the kind of work the chosen practice entails. Approach potential champions only after it is understood by management that the role of champion may take considerable time, and that the champion may need changes in their workload to successfully fulfill that role. This role does not work well as an additional or involuntarily assigned duty. It is best if staff volunteer, otherwise their efforts may be seen as another item under the “other duties as assigned” portion of their job description, or an example of the always-popular “you’re such a productive team member we’re going to reward you with more work.”***

With the practices defined, and management and champions on board, it is now time to assign work groups to implement the charge for each EBP. The work groups should be made up of stakeholders, including the champions, quality improvement personnel, Supervisors, frontline staff, and consumers. The membership of each work group will likely evolve and change over the course of the implementation.



**Tip:**

***Crossover membership is useful in making sure work groups are not operating at cross-purposes or duplicating efforts. A useful approach is to have each work group report to a single committee (e.g., the Quality Improvement Committee) that is responsible for seeing the larger picture.***

## ***3.0 Developing the Work Plans***

Project work plans are the maps that will be used for implementation roll-out. It is critical to take the time to pay sufficient attention to detail when developing this plan. It should ideally include all the territory your organization will need to cover to implement EBPs. The map is never the territory, so the work plan will require changing as the terrain is traversed. The work plan is intended to be a living document, meaning it is open to revision. The charge, however, should not change, as it is the foundation upon which the work plan is built.

There are a variety of work plan templates and formats, as well as project management books and software that can be used to help create a work plan structure. A well-developed set of guidelines for work-plan development can be found in **APPENDIX A: The Community Mental Health Partnership of Southeastern Michigan *Policy and Procedure for Approval and Implementation of New Programs***. An applied example of a smaller project work plan is provided for reference purposes in this field guide in **APPENDIX G**.

### ***3.1 Assess Organizational Capacity for Implementation***

A work plan that has been well thought out provides the organization a step-by-step approach to achieving the final outcome of systems integration of multiple EBPs. Systems integration can only occur if what needs changing is known, as well as who can effect the desired change. **Assessing capacity, identifying barriers and building consensus** are the means through which the work plan is developed. Some barriers will cut across all the EBPs being implemented, while others will be practice-specific. Barriers can only be addressed if everyone agrees on what the barriers are, and how they are to be overcome. Therefore, moving forward to address barriers requires consensus on both their identification, and what solutions may apply. In this way, assessment of capacity reveals barriers that can only be overcome through consensus-

building. Keep this process in mind when talking with staff. The overall goal of consensus-building in developing the work plan is to involve stakeholders as an important part of the decision-making.

Fixsen, Naoom, Blasé, Friedman & Wallace (2005, 64-65) found the following elements for organizational change important to successful action:

- 1. Commitment of leadership to the implementation process;**
- 2. Involvement of stakeholders in planning and selection of programs to implement;**
- 3. Creation of an implementation task force made up of consumers and other stakeholders;**
- 4. Suggestions for “unfreezing” current organizational practices;**
- 5. Resources for the extra costs, effort, equipment, manuals, materials, recruiting, access to expertise, and re-training for new organizational rules associated with implementation of the innovation;**
- 6. Alignment of organizational structures to integrate staff selection, training, performance evaluation, and ongoing training;**
- 7. Alignment of organizational structures to achieve horizontal and vertical integration;**
- 8. Commitment of ongoing resources and support for providing time and scheduling for coaching, participatory planning, exercise of leadership and evolution of teamwork.**

We found this list of elements helpful, as it provides meaningful reference points to use when evaluating capacity to implement.

There are several key areas of organizational capacity that require examination early on in the development of the work plan. When starting multiple EBPs, a single assessment can provide the information needed to begin all the practices. However, if you are staggering practice implementation, a new baseline assessment will be needed when

each new practice is introduced. It is this initial capacity assessment that becomes the starting point for developing sustainability through ongoing fidelity monitoring. The General Organizational Index (GOI), developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), is an instrument in the public domain that provides an example of one such capacity assessment tool. Each of the evidence-based practice toolkits available from SAMHSA contains both a General Organizational Index (GOI), as well as an EBP-specific Fidelity Scale. It is worthy of note that the GOI for each and every evidence-based practice is the same; that is, the organizational system elements deemed important for successful EBP implementation are understood to be the same no matter if an agency is planning to launch Family Psychoeducation (FPE) services, an Assertive Community Treatment (ACT) team, or Integrated Dual Disorders Treatment (IDDT). Paying attention to these critical foundational elements is of great importance to an organization seeking to implement more than one EBP, in order to maximize the chances of successful launch and sustainability. The GOI domains are as follows:

<b>G1</b>	<b>Program Philosophy</b>
<b>G2</b>	<b>Eligibility / Client Identification</b>
<b>G3</b>	<b>Penetration</b>
<b>G4</b>	<b>Assessment</b>
<b>G5</b>	<b>Individualized Treatment Plan</b>
<b>G6</b>	<b>Individualized Treatment</b>
<b>G7</b>	<b>Training</b>
<b>G8</b>	<b>Supervision</b>
<b>G9</b>	<b>Process Monitoring</b>
<b>G10</b>	<b>Outcome Monitoring</b>
<b>G11</b>	<b>Quality Assurance (QA)</b>
<b>G12</b>	<b>Client Choice Regarding Service Provision</b>

More detailed application of these domains is informed by considering their definitions, and the way in which the EBP toolkits recommend measuring an organization's status in each category.

	1	2	3	4	5
<p><b>G1. Program Philosophy.</b> The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources:</p> <ul style="list-style-type: none"> <li>▪ Program leader</li> <li>▪ Senior staff (e.g., executive director, psychiatrist)</li> <li>▪ Practitioners providing the EBP</li> <li>▪ Clients and/or families receiving EBP</li> <li>▪ Written materials (e.g. brochures)</li> </ul>	No more than 1 of the 5 sources shows clear understanding of the program philosophy OR All sources have numerous major areas of discrepancy	2 of the 5 sources show clear understanding of the program philosophy OR All sources have several major areas of discrepancy	3 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one major area of discrepancy	4 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one or two minor areas of discrepancy	All 5 sources display a clear understanding and commitment to the program philosophy for the specific EBP
<p><b>*G2. Eligibility/Client Identification.</b> All clients with severe mental illness in the community support program, crisis clients, and institutionalized clients are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP. Also, the agency tracks the number of eligible clients in a systematic fashion.</p>	≤20% of clients receive standardized screening and/or agency DOES NOT systematically track eligibility	21%-40% of clients receive standardized screening and agency systematically tracks eligibility	41%-60% of clients receive standardized screening and agency systematically tracks eligibility	61%-80% of clients receive standardized screening and agency systematically tracks eligibility	>80% of clients receive standardized screening and agency systematically tracks eligibility
<p><b>*G3. Penetration.</b> The maximum number of eligible clients are served by the EBP, as defined by the ratio: <math>\frac{\# \text{ clients receiving EBP}}{\# \text{ clients eligible for EBP}}</math></p>	Ratio ≤ .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80

*\*These two items coded based on all clients with SMI at the site or sites where the EBP is being implemented; all other items refer specifically to those receiving the EBP.*

\_\_\_\_\_ Total # clients in target population

\_\_\_\_\_ Total # clients eligible for EBP

\_\_\_\_\_ Total # clients receiving EBP

% eligible: \_\_\_\_\_%

Penetration rate: \_\_\_\_\_

<p><b>G4. Assessment.</b> Full standardized assessment of all clients who receive EBP services. Assessment includes history and treatment of medical/psychiatric/substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.</p>	Assessments are completely absent or completely non-standardized	Pervasive deficiencies in two of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness	Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness	61%-80% of clients receive standardized, high quality assessments at least annually OR Information is deficient for one or two assessment domains	>80% of clients receive standardized, high quality assessments, the information is comprehensive across all assessment domains, and updated at least annually
<p><b>G5. Individualized Treatment Plan.</b> For all EBP clients, there is an explicit, individualized treatment plan <i>related to the EBP</i> that is consistent with assessment and updated every 3 months.</p>	≤20% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i> , updated every 3 mos.	21%-40% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i> , updated every 3 mos.	41%-60% of clients served by EBP have an individualized treatment plan, <i>related to the EBP</i> , updated every 3 mos. OR Individualized treatment plan is updated every 6 mos. for all clients	61%-80% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i> , updated every 3 mos.	>80% of clients served by EBP have an explicit individualized treatment plan <i>related to the EBP</i> , updated every 3 mos.

	1	2	3	4	5
<b>G6. Individualized Treatment.</b> All EBP clients receive individualized treatment meeting the goals of the EBP.	≤20% of clients served by EBP receive individualized services meeting the goals of the EBP	21%-40% of clients served by EBP receive individualized services meeting the goals of the EBP	41%-60% of clients served by EBP receive individualized services meeting the goals of the EBP	61% - 80% of clients served by EBP receive individualized services meeting the goals of the EBP	>80% of clients served by EBP receive individualized services meeting the goals of the EBP
<b>G7. Training.</b> All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) <i>within 2 months of hiring</i> . Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).	≤20% of practitioners receive standardized training annually	21%-40% of practitioners receive standardized training annually	41%-60% of practitioners receive standardized training annually	61%-80% of practitioners receive standardized training annually	>80% of practitioners receive standardized training annually
<b>G8. Supervision.</b> EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application to specific client situations.	≤20% of practitioners receive supervision	21% - 40% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision on an informal basis	41%-60% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision monthly	61%-80% of EBP practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision twice a month	>80% of EBP practitioners receive structured weekly supervision, focusing on specific clients, in sessions that explicitly address the EBP model and its application
<b>G9. Process Monitoring.</b> Supervisors and program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators.	No attempt at monitoring process is made	Informal process monitoring is used at least annually	Process monitoring is deficient on 2 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 mos.; (3) Used to guide program improvements OR Standardized monitoring done annually only	Process monitoring is deficient on one of these three criteria: (1) Comprehensive and standardized; (2) Completed every 6 months; (3) Used to guide program improvements	Standardized comprehensive process monitoring occurs at least every 6 mos. and is used to guide program improvements
<b>G10. Outcome Monitoring.</b> Supervisors/program leaders monitor the outcomes for EBP clients every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome related to the EBP, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs	Outcome monitoring occurs at least once a year, but results are not shared with practitioners	Standardized outcome monitoring occurs at least once a year and results are shared with practitioners	Standardized outcome monitoring occurs at least twice a year and results are shared with practitioners	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners
<b>G11. Quality Assurance (QA).</b> The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components of the program, every 6 months.	No review or no committee	QA committee has been formed, but no reviews have been completed	Explicit QA review occurs less than annually OR QA review is superficial	Explicit QA review occurs annually	Explicit review every 6 months by a QA group <i>or steering committee for the EBP</i>

	1	2	3	4	5
G12. Client Choice Regarding Service Provision. All clients receiving EBP services are offered choices; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.	Client-centered services are absent (or all EBP decisions are made by staff)	Few sources agree that type and frequency of EBP services reflect client choice	Half sources agree that type and frequency of EBP services reflect client choice	Most sources agree that type and frequency of EBP services reflect client choice OR Agency fully embraces client choice with one exception	All sources agree that type and frequency of EBP services reflect client choice

In terms of educating key personnel at all organizational levels, and setting realistic expectations for what is required for successful EBP implementation, the GOI can be a helpful tool. (<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/> )

In addition, we recommend expanding the capacity assessment process to include the following:

### 1. Finance

This involves assessing how the organization will translate these new practices into billable activities of the organization. Recognize that different funding systems (e.g. fee for service or capitated systems) have different capacities to reimburse EBPs. Some systems may not have billing codes, or may require a licensed practitioner (rather than a Case Manager or Peer Support Specialist) to deliver the service.

### 2. Support Staff

Assess how Support Staff responsibilities will change. For example, will Support Staff be asked to add responsibilities such as helping arrange transportation, or ordering food? These small tasks can add up to a major change in work flow for Support Staff when multiple EBPs are implemented.

### 3. Organizational Policies

Assess how current organizational policies may support or obstruct implementation of EBPs. Some examples may include the need for new or expanded policy development around clinical practice guidelines, consumer involvement, transportation, food, childcare, staff credentialing, multidisciplinary team make-up, nontraditional clinic times, union issues around new job duties, etc.

When looking at organizational capacity, staff need to understand why you are taking these actions. Regular meetings with staff and consumers, newsletters, and a rapid response to rumors generated in the workplace or community will help to make the process smoother. Ideally, staff should see the capacity assessment as a way to learn about current service needs, concerns and areas of strength.



**Tip:**

Check out the **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** “**Recommendations for QI Practice Implementation and Monitoring**” ([www.jointcommission.org/](http://www.jointcommission.org/)).

*They suggest a list of questions to ask when considering implementing EBPs, including the following emphases (Hayes, 2001).*

- *Does your agency measure functional outcomes at intake, discharge and during regular intervals in between?*
- *Does your agency assure each treatment plan has measurable outcomes?*
- *Has your agency developed standardized treatment protocols for any specific diagnostic condition?*
- *Has your agency trained Supervisors and staff to understand the statistical processes necessary to interpret aggregated clinical or performance improvement data?*



**From the Field:** *In a large urban area in Michigan, the Community Mental Health center administration did not begin discussing the implementation of EBPs until the organization responsible for funding services had identified necessary new billing codes for the EBP services. The funding codes were negotiated in such a way to take into account the billable hours that were displaced by the hours spent by staff implementing the practice.*



***Tip:***

A useful tool in identifying resources is a “**Stop Doing List**”. This list details what practices will be replaced by the new EBPs. Resources formerly committed to these activities can then be shifted to the provision of the new practices. The list must be developed with the staff who are being asked to change their work processes. It may seem obvious that this shifting would occur, but often administrators and project leaders forget to spend time on this important step. In the “heat of implementation,” it just makes sense to them that staff would agree that a particular work process would need to stop. Remember, people typically don’t mind changing their work practices – they just don’t like feeling **FORCED** to change their work practices. The difference has to do with getting consensus.



***Tip:***

It is important that, whenever possible, clinical staff not be asked to order food, arrange transportation, take minutes for work group meetings, or perform other duties typically assigned to Support Staff. Many organizations ask clinicians to pick up this extra work due to lack of funding, or unwillingness to expand Support Staff duties. While this may appear cost-effective, it is not. This additional work that may fall to clinical staff can be a primary contributor to burnout, and a contributing factor to poor motivation for implementing the practice.



***From the Field:*** Prior to implementing Integrated Dual Disorders Treatment (IDDT), staff were responsible for evaluating a consumers’ ability to pay. We decided to

*stop this practice in order to free up staff time to provide better treatment services. “Care Manager” positions were created out of existing Support Staff positions, focusing on assessing consumer ability-to-pay, and the collection of insurance co-pays. The cost savings from stopping the practice of having clinical staff assessing ability-to-pay was considerable. In the first year insurance billing and collection more than doubled, at the same time allowing clinical staff to do their work more effectively.*



**Tip:**

*A cost-effective way to reduce costs and to increase consumer involvement in services is to hire **Peer Support Specialists** to assist clinicians in the provision of evidence-based practice services.*

### **3.2 Assess Barriers and Build Consensus**

As already noted, the process of assessing organizational capacity also begins the process of barriers assessment and consensus building. We suggest that the assigned work groups do the formal capacity review using the GOI. The work groups can then meet to review organizational capacity findings, and to begin to identify barriers. Work group consensus is built by discussing what solution best fits each barrier. Each solution should have an assigned person responsible for putting the solution into action, a listing of resources (including people) necessary to achieve the solution, a clearly defined outcome, and a timeline. Some barriers and their solutions will be very obvious and not require much discussion. Other barriers may bring to light longstanding issues within the organization that require further resolution. Some barriers may be so large or intimidating that the work groups may be at a loss about how to address the identified needs.



## Resources:

**For an example of a Barriers Work Sheet, see APPENDIX B.**

Once organizational capacity has been detailed, and barriers have been charted out with corresponding solutions, it is time to formally meet with staff and other stakeholders. Each work group member can be assigned to develop consensus with stakeholders through a process of bringing the identified barriers to stakeholders to brainstorm ideas and solicit input about solutions. It is important not to bring every barrier to the stakeholders – **bring only those barriers that you need their help to solve or clarify.** The barriers assessment and solutions meetings need to be facilitated by strong leaders prepared to keep the conversation positive and solution-focused. It is easy to have these meetings spiral into negative discussions, or to leave stakeholders with the feeling that you are just going through the motions, and not sincerely asking for their input. That is why it is important that the work groups clearly understand what they are asking of the stakeholder group. If the stakeholders don't see a barrier, or see the true barrier as something other than what is identified, it is important for the facilitators to be able to keep the discussion constructively focused on an agreed-upon barrier, and a realistic, action-oriented solution.



### **Tip:**

*One general but critical step is to help your organization understand the importance of each of the evidence-based practices. Develop with your administrators and staff a shared vision of how integrating evidence-based practices can improve service quality and outcomes for consumers and families. This involves sharing with staff and administrators national research findings that identify the need for service / outcome improvements. The shared vision of improved service quality and financial*

*stewardship is typically a meaningful one for clinicians and organization leaders alike.*



***From the Field:*** *With regard to IDDT service needs, staff found it validating to learn that the national prevalence rates of substance use disorders within the chronically mentally ill population are typically 50% or higher, depending on the study. It is probably rare that a clinician will not have had some amount of frustrating experience with one or more substance-involved consumers, whose mental health stability has been compromised due to the lack of better integrated, co-occurring addictions treatment. Referencing these experiences can contribute to framing the implementation of IDDT services as a much more effective way to serve consumers, with “win-win” benefit – greater wellness for clients, and less frustration for clinical staff. For administrators, outcomes efficacy is an important emphasis on which to focus, including sharing data from national studies about the improved outcomes that occur when IDDT services are available.*

During these steps of consensus-building, don't forget to approach key opinion leaders in the organization to make sure they are on board with the implementation. Ask for their advice and actively include them in the roll-out process.



***From the Field:*** *While implementing the Family Psychoeducation practice, we knew there was a very talented and experienced clinician who was respected among peers as an opinion leader. If this person was not on board, it was likely that the implementation would be slowed or disrupted. While not necessarily interested in taking a leadership role in the implementation, this person was deliberately, visibly, and sincerely approached by the work group for input.*

Make sure **all** key decision makers (e.g. board chairs, finance managers, etc.), both within and outside of the organization (e.g. advocacy leaders), are included early in the process of addressing barriers.

The process of assessing capacity will provide many examples of what your organization will need to address prior to attempting formal practice implementation. At this point there may be a more heightened awareness of how much work the organization is facing. Some of the revealed capacity deficits may represent significant barriers that could set back your efforts. The good news is that you have significant resources in the form of the partners who have been recruited to help by developing consensus through working on barriers and solutions.



**Tip:**

*It is important to recognize that the pre-existing work of the organization continues while new evidence-based practices are being phased in. Establishing a newsletter or communication plan to keep all staff and administrators informed about the implementation steps is an excellent strategy with which to keep efforts progressing effectively.*



**Resources:** Here's an example of a newsletter used to communicate with stakeholders:

## Evidence-Based Practices Update *The Layering Evaluation Project*

Newsletter of the CMH Partnership of Southeast Michigan

October 4, 2005

### The Layering Evaluation Project

The WCHO and CSTS have been engaged in an evaluation process to examine lessons learned from the layering of three evidence-based interventions in one organization. The layering project is funded by a State of Michigan Department of Community Health grant awarded to the University of Michigan. Layering refers to offering more than one evidence-based practice in the same organization. The three evidence-based interventions include: Assertive Community Treatment (ACT), Multiple Family Group Psychoeducation

(MFG) and Integrated Dual Disorders Treatment (IDDT).

Reflecting on the challenges of integrating more than one evidence-based practice in one organization and examining what works when implementing three evidence-based programs are central areas addressed by the evaluation project.

During the Summer of 2005, WCHO and CSTS staff participated in focus groups and CSTS staff completed surveys that examined worker beliefs about evidence-based practices and experiences with implementing the

three identified evidence-based models.

A total of 10 focus groups were held with over 83 WCHO and CSTS staff participating in the sessions. In addition, over 80 CSTS staff completed a written survey that examined their beliefs about evidence-based practices and their experiences with the current implementation of the three evidence-based models.

The key findings from these focus groups and surveys will be highlighted in this brief newsletter.



### How is the layering of evidence-based practices working?

A majority of the staff in each of the focus groups reported that for the most part the layering of ACT, MFG and IDDT has gone "very well".

While not all the groups had experiences with more than one evidence-based intervention/program, those that did felt that the three models "fit

well together".

Participants report that families and consumers have given positive feedback about the evidence-based interventions/ programs that they are involved in at the agency.

In particular, staff found that the focus on recovery to be a positive one and that supervision by the "experts" is an

added bonus during the implementation phase of the interventions. Staff also reported that they now partner more with consumers and families as a result of engaging in these evidence-based practices. Several staff reported that these evidence-based models promote building consumer and family networks to support recovery. Staff partner more with consumers and families.



***From the Field:*** *Early in the consensus-building stage of implementing the FPE practice, staff raised specific concerns that were potential obstacles to implementation. These concerns included large caseload sizes, the time commitment required for training, and the reduction of billable hours. These issues were not new to the organization, but had also come up at other times with other service enhancements. Implementing EBPs created opportunities for staff and administration to work together to address these and other issues that needed to be resolved in order to progress with implementation.*



***From the Field:*** *Concurrent with the advent of the EBP movement came a new understanding of IDDT service-provision as an expected element of generalist practice at our organization. In our organization's recent history, case management provision, in particular, had followed more of a "broker" model by which staff primarily connected clients with indicated and available services from other sources. Implementation of an integrated model for dual disorder treatment (as well as other EBPs) carried with it the expectation that each service-providing staff member would become capable, within their respective scope of practice, to provide EBP-informed, or EBP-specific services. Case Managers who had previously operated as service brokers were now asked to become competent at a host of other generalist functions, including providing IDDT-informed psychoeducation, clinically supportive drug testing, motivational counseling, and the facilitation of certain groups.*



***From the Field:*** *Prior to the implementation of the Family Psychoeducation practice, the organization had been involved in general family psychoeducation primarily through supporting the local NAMI chapter in providing family education classes. Case Managers were open to working with family members who had obtained consent and wanted to be involved in their loved one's care. However, there was no program in place to formally recruit, educate and involve family members in the care of their loved one. Likewise, there was no formal model to educate consumers about the benefits of*

*including their family members and natural supports in their care, although the practice of Person-Centered Planning encourages asking about involving natural supports in treatment. However, a specific model explaining how to do this (complete with fidelity guidelines) did not exist within the organization. We learned soon after beginning FPE training that most of the Case Managers, while open to learning, did not know how to approach educating family members. Further, many genuinely believed they were not “qualified” to talk about the etiology and treatment of schizophrenia and other mental illnesses. Case management staff were comfortable advocating and referring consumers to community supports related to housing, entitlements and employment. While knowledgeable about severe and persistent mental illness, they saw themselves more as brokers of care than as clinicians. Further, few staff had ever previously facilitated a group. As a result of these barrier findings, it was indicated that Supervisors and Senior Clinicians spend time training through role-playing and sitting in on meetings with families. Inexperienced staff were paired with staff experienced in group facilitation. The movement toward a more family-focused model of case management also had other unexpected consequences, including the need to discuss with union officials and staff how this new approach did not mean that staff job descriptions were changing to include duties previously performed only by therapist-level clinicians. The Family Psychoeducation model required that staff access areas of knowledge many of them already possessed, but had not necessarily acknowledged to themselves.*

### **3.3 Manage Resistance**

If significant resistance to the idea of integrating evidence-based practices is encountered, you might consider simply piloting each of the EBPs only with the staff who are highly motivated to try the new practices. In fact, it may work best to use a phase-in approach to implementing the new evidence-based practices. Part of your job as the Program Manager or Clinical Supervisor during this entire process is to create a climate that supports staff in making the transition to evidence-based practices. As

previously mentioned, consensus-building is an ongoing process throughout the entire implementation.



**Tip:**

*One option that can help facilitate the integration of multiple EBPs in an organization involves surveying staff about how they view evidence-based practices, and about their willingness to try new approaches. Conducting team meetings to talk about staff concerns as the organization moves forward with EBPs is one effective means to this end. The **“Evidence-based Practice Attitude Scale”** developed by Aarons (2004) can be used to gauge the “readiness” of staff to adopt evidence-based practices and programs. Some sample items from this scale solicit input on the following statements:*

- “Research based treatments / interventions are not clinically useful.”
- “Clinical experience is more important than using manualized therapy / interventions.”
- “I would not use manualized therapy / interventions.”
- “I would try a new therapy/intervention even if it were very different from what I am used to doing.”



**From the Field:** *Creating a climate conducive for IDDT implementation in our organization involved several processes that helped to manage some of the predictable resistance. We invited staff to be a part of an initial set of meetings to identify barriers and solutions related to implementing the IDDT evidence-based practice. We appealed to professional ethics and values – once the prevalence of dual disorders was empirically established, it only made sense to most staff that the “right thing to do” was to improve our organization’s ability to treat dual disorders more effectively. We painted the vision of more effective treatment leading to decreased professional frustration and stress in working with the dually diagnosed population. We offered an incentive by which bachelor’s-level case management staff who obtained the Certified Addictions Counselor credential (a Michigan substance abuse treatment*

certification) could receive a salary and position upgrade. In certain cases, we reduced workloads somewhat so that clinicians could have the capacity to facilitate co-occurring disorder treatment groups. We offered a considerable amount of training so that staff could feel equipped and confident to participate in providing IDDT-informed services. And we also provided ongoing, regular supervision to oversee professional learning, and to support clinicians willing to “step out” in this new direction. Several years prior to the recent EBP movement, our organization had a separate and discrete “Dual Diagnosis Unit” to which other units’ staff could refer their substance-involved clients for ALL services, “lock, stock and barrel.” By contrast, our current Dual Disorders Treatment implementation calls for the integration of indicated co-occurring disorders treatment competencies across the entire organization, in each scope of practice. For example, this has included the expectation that Case Managers be able to provide appropriate psychoeducation on addictions-related matters, rather than always deferring to medical or therapist staff. Other core competencies that are becoming expectations include: the ability to recognize some of the indicators of active substance abuse, and to either be able to conduct an assessment oneself, or to be able to refer that client to the co-occurring addictions specialist on one’s team; knowledge of organization and area treatment resources that are available to clients with dual recovery needs (including detoxification, residential treatment and 12-Step fellowship resources); and engagement skills (including Motivational Interviewing) that can be brought to bear when interacting with clients showing less-than-action-stage readiness to change.



**Tip:**

*If the organization is undergoing financial cuts, this needs to be clearly defined in relation to the practice implementation, to manage the risk of staff confusing the two. Negatively associating EBPs with downsizing or cost-cutting would put an unnecessary obstacle in the way of successful implementation.*

The challenges of moving to a new model of practice can be managed proactively in some respects by administration, as this next note from the field illustrates.



***From the Field:*** *When Family Psychoeducation was being introduced at our agency, the administration assured staff that they would see a reduction in their caseload sizes. Average caseload size did NOT, in fact, decrease and staff did not see many immediate, tangible benefits for starting up the FPE groups. Staff were also resistant to having to change their hours to the evenings to be able to meet with clients' families for joining sessions, and to run the groups. Despite being allowed to shift their hours and come in at noon on group days, some staff were embittered by the entire process, and the perception of failed promises. Some sites had groups start, then collapse, and then start again. It was not until 2002 that all sites had groups up and running. After all was said and done, the FPE groups ended up being led by staff who enjoyed the groups, and feel that their work is enhanced by them. At ACT, where the first multi-family group in Michigan was started, staff were never promised any reduction in caseload, nor did we have the expectation that services for the clients in the group would drop. The ACT staff running the groups were volunteers who were excited about adopting a new treatment modality. The primary reward was the positive recognition for their hard work from their Supervisor, the organization, the local NAMI chapter, families and clients. Eventually, our CSTS organization did provide staff with flex / compensation time for extra hours that needed to be worked in order to implement this new EBP.*

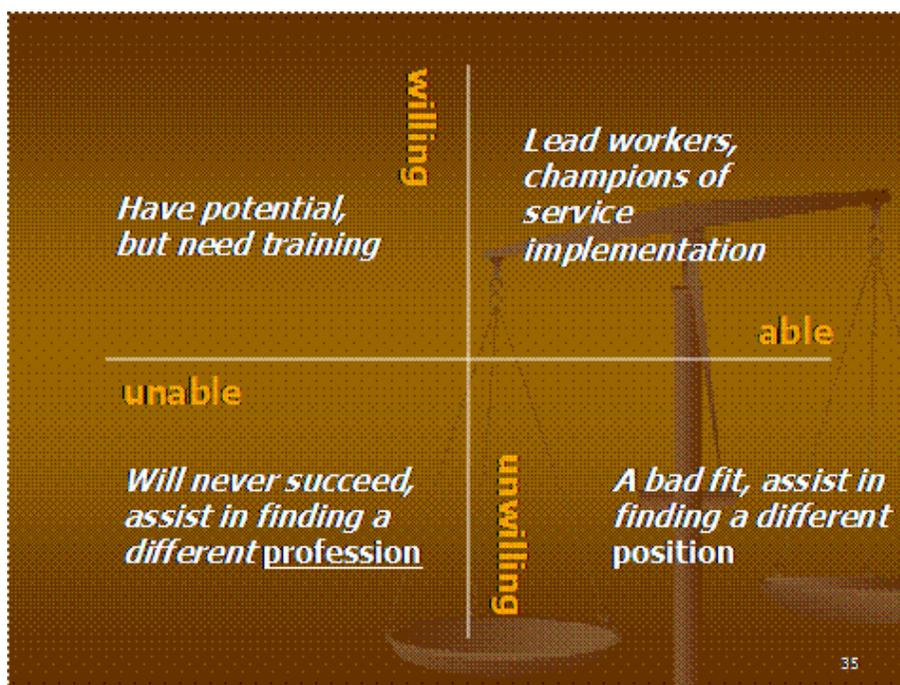


**Tip:**

*While listening to staff and consumer concerns, do not make promises that you can't or aren't willing to fulfill. Trust and credibility are key factors in managing resistance and in other collaborative efforts that are part of implementing multiple EBPs.*

Sometimes no matter how much effort has been put into building consensus within the organization, and no matter how proactive agency leadership has been to manage

resistance, certain employees may still actively resist the changes involved with implementing EBPs. Progressive disciplinary action may be necessary to send a strong and consistent message that because practice improvement is so critical to better outcomes for consumers, an employee's lack of appropriate participation and cooperation will not be tolerated. A local trainer in Clinical Supervision for addictions-treatment providers (Tom Foley) recommends utilizing the “Willing and Able Matrix” to guide Supervisor responses to such staff situations.



**“Willing and Able” Matrix**

Those employees who are both “willing and able” are the likely champions of EBP implementation, and the staff that bring the biggest return for supervisory investment. Those employees who are “willing but unable” are likely in need of training and coaching to improve their competencies – again, well worth the investment from management to bring them along. However, those staff who are “able but unwilling” require a different response. This may likely include the use of close monitoring, encouragement, and perhaps progressive discipline to try to facilitate the necessary attitude adjustment that would help them to become allies in realizing the promise of practice improvement that EBP implementation brings. If the needed changes are not

forthcoming, the longer-term solution may involve helping that employee to find a different position within the agency (or with another employer), that does not require highly competent service provision to vulnerable clients who need effective help with their serious mental health and co-occurring substance use disorders. Lastly are the “unable and unwilling” staff, who lack both the competencies to provide evidence-based services, as well as the willingness to learn such skills. The advice for this group of employees is to administer progressive disciplinary action until they are terminated. Not only that, but it may be worth considering declining to provide a positive reference to other potential employers in the field, as such staff may carry a high risk of jeopardizing the well-being of clients at other clinical service provider agencies if re-employed within the human services profession.

### ***3.4 Develop Timelines***

An integral part of building work plans involves the development of functional timelines that lend motivation, and accountability, to the EPB implementation process. Prior to now, you may have already had a general idea of the sequence of involved steps, or even have had the benefit of one or more available Field Guides or toolkits to assist with implementation action-planning. However, now that the recommended planning process has been informed by the data gathered through the assessments of organizational capacity, barriers, and staff readiness, some more detailed and useful timelines can be constructed for each evidence-based practice.

Timelines should be aggressive yet realistic. Recognize that adding evidence-based practices will initially require significant effort by all levels of the organization, but especially by the clinical personnel. If staff experience high levels of frustration, or lack of support to initiate change, then significant resistance can be expected, so take your time and err on the side of addressing the barriers first before expecting staff to implement new practices.



***From the Field:*** An example of a timeline sequence for the Dual Disorders treatment implementation can be found in **APPENDIX C**.

### **3.5 Work with Administration**

With the capacity assessment completed, each domain within the assessment has identified barriers and solutions. Prior to moving forward with assigning the staff responsible for implementing solutions, seek administrative buy-in. **Solutions require resources.** Do not promise solutions to stakeholders until approval for necessary resources has been obtained from administration. Once administration is on board you can go ahead with implementing the solutions knowing full well this process of identifying capacity needs, barriers to addressing the need, and consensus-based solutions is an ongoing process.

*In summary,* developing work plans is a lengthy process. It is not unusual for this process to take six months or more. Take your time during this phase. Patience and hard work will pay off during the implementation phase where new barriers will be easier to overcome because solid consensus and clarity of purpose allows for people to find solutions more quickly and come to agreements more easily.

## ***4.0 Implementing the Evidence-Based Practices***

Implementing multiple evidence-based practices requires attention to the “fit” between the organizational context and the components of each new EBP. It is important to maintain a systems perspective on these change processes. Your task is to make sure that you are creating supportive environments within the organization to make it easier to implement the evidence-based practices. The solutions to barriers identified earlier will address many of these concerns.

The goal of implementation is to have practitioners base their interactions with clients and stakeholders on research findings (Fixsen et al., 2005) while allowing for the clinicians’ unique personal styles to remain intact. In a review of the literature on implementation of evidence-based practices, Fixsen et al. (2005) identified the following core components that need to be addressed for successful results: **staff selection, pre-service and in-service training, ongoing consultation and coaching, staff and program evaluation, facilitative administrative support, and system interventions.** These core elements are even more critical when implementing more than one evidence-based practice in the same organization.

### ***4.1 Use Logic Models***

Your initial task is to determine how you will phase-in each evidence-based practice in a manner that maximizes success, ensures fidelity to the practice, and fosters continued commitment to delivering evidence-based interventions across the organization. One step that can be extremely helpful is to develop a logic model for each evidence-based practice and to identify all of the practice principles that will guide each EBP.



## **Resources:**

The **W.K. Kellogg Foundation Logic Model Development Guide (located at: [www.wkkf.org](http://www.wkkf.org))** provides the underlying principles of "logic modeling" and step by step guidance to facilitate use of logic models to enhance program planning, implementation, and dissemination activities.

These initial logic models will help you and your stakeholder groups to visualize the implementation process, and will allow for the identification of steps needed for implementation based on the theory of planned change reflected in the logic models.



***From the Field:*** An example of a logic model developed for the Family Psychoeducation (FPE) implementation can be found in **APPENDIX D**.

## **4.2 Develop and Use Principles of Practice**

Evidence-based Practice Fidelity Scales and Clinical Practice Guidelines (CPGs) are very helpful in supporting staff in the roll-out of the practice. Clinical Practice Guidelines detail the practice method in a step-by-step fashion which allows staff to flow-chart the processes they will use to deliver the practice. Fidelity Scales have both clinical process components, as well as structural components, that are relevant to your organization as a whole (e.g. staffing ratios). Your organization will want to use available Fidelity Scales and CPGs as a basis for developing your organizations' "Principles of Practice". Principles of Practice are guidelines for a practice specific to a particular to your organization. Principles of Practice identify the CPG and fidelity components that your organization has had to adapt in order for the EBP to be effectively delivered by your organization.

 **Resources:**

***Examples of IDDT and FPE Principles of Practice can be found in APPENDIX E.***

Fidelity scales will allow you to monitor the implementation. Fidelity scale scores will often correlate well with the capacity assessment. Where capacity was found to be lacking, the fidelity scores should improve as capacity improves. Fidelity to the practice can be seen as a cookbook approach to providing services, and insofar as it is a detailed approach to providing a practice, it is. However, staff should be reminded that fidelity is only one component of the practice. It is staff's ability to create a supportive relationship focused on hope and recovery that truly makes evidence-based practices effective. If adopted, Clinical Practice Guidelines, Fidelity Scales, and resulting Principles of Practice will allow staff to create efficiencies in their practice so they can focus on the relationship with the people they serve.

### ***4.3 Manage Deviation from Fidelity***

Your organization may need to modify the evidence-based practices to maximize positive outcomes for your consumers. Consult with experts in the evidence-based practice area to see how other organizations have dealt with similar issues. Any modifications to the practice should have a detailed rationale for the changes and be incorporated into the Principles of Practice. These changes should be noted in any fidelity assessments, and tracked closely for consistency according to Clinical Practice Guidelines. This allows the level of monitoring necessary to see what is and isn't effective in any local adaptations. It could very well be that a modification your organization makes could be linked to better outcomes for consumers and become a new item in the pertinent clinical practice fidelity scale!

**Resources:**

**Each SAMHSA Toolkit for the EBPs contains a Fidelity Scale for that EBP. You will find these fidelity scales very helpful in the training, implementation and sustainability phases of your work.**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp>

## ***4.4 Train and Supervise Staff***

Review the training and supervision needs of the staff for each of the evidence-based practices. Assess who in the organization will receive training and supervision specific to the practice area. Secure the needed funding to ensure that staff will receive ongoing supervision from professionals already certified in the evidence-based practice. Staff who are trained in one or another evidence-based practice may eventually become the trainers within your own organization. It is helpful to think about piloting each evidence-based practice with clinicians who volunteer or are highly motivated to deliver evidence-based interventions. After each practice is initially implemented with sufficient fidelity, and staff are experienced and certified in the practice, additional staff can then be engaged in the delivery of the involved services.

**Tip:**

***The evidence-based practice of Motivational Interviewing comprises a skill set that cuts across all EBPs. Training staff in Motivational Interviewing techniques will greatly improve their ability to deliver all EBPs with greater efficacy.***



***From the Field:*** *Our organization’s IDDT “purveyor” base was covered by a combination of external consultation and coaching (Drs. Kenneth Minkoff, Robert Drake, and David Mee-Lee), and identification of internal personnel with the necessary skills, experience and knowledge. Our IDDT “implementer” base was covered through the identification and development of existing staff, in addition to a conscious effort to recruit and hire new personnel with IDDT competencies into existing positions in which there was staff turn-around during our organization’s implementation efforts.*

Be prepared to manage conflicts that can emerge when staff begin providing the practices, and be prepared to engage in active conflict-resolution activities. Check in frequently with clinicians and consumers to assess commitment to the implementation of the practices. In some situations, you will find that staff may have been willing to complete the involved trainings, but really had no commitment to actually deliver the intervention, especially if it required a change in work hours or caseload mix. Remind staff that the new practices should replace and upgrade current practices instead of being viewed as add-on services. This is the notion previously mentioned of needing to have a “Stop-Doing List”. Familiar work flow can often represent a very difficult set of behaviors to change. Staff will fall back on old patterns of providing service and will need to be reminded of the benefit of providing these new practices, both to themselves and to the people they serve. Be sure to actively seek out consumer and staff input regarding how to transition to the new practices.

The notion of training an agency’s entire workforce within a short period of time to become competent at not only one EBP, but more than one, is overwhelming at the very least, and perhaps even impossible! So how does an agency move toward greater competency at implementing multiple EBPs? Two strategies will be discussed here, which have been found to be helpful in our organization’s experience – ***representation of each EBP on a given treatment team***, and ***taking advantage of competencies and practice areas that overlap between the various EBPs***.

The first strategy involves utilizing a team model of service delivery featuring representation of various disciplines and scopes of practice within the team. This general concept is already in use within various CMH organizations and other agencies, as a realistic means by which various types of expertise can be brought to bear on the quality of care delivered to a particular client, without every team member being expected to attain the highest level of expertise in multiple disciplines. A typical multidisciplinary team includes representation of the service components of psychiatry, nursing, therapy, and case management. With regard to the implementation of various EBPs, an immediate goal would be to have expert representation of each particular EBP on a given treatment team. For example, focusing on training a few IDDT Addictions Specialists, or a couple of Family Psychoeducation (FPE) Group Facilitators is much less daunting, and much more realistic, than trying to get an entire workforce ramped up at the highest level of expertise with regard to each particular EBP.

This is not to say that upgrading the education and competencies of an entire workforce is not part of the long-term picture, as it most certainly is. However, more immediate implementation seems to require an Implementation Champion on each pertinent team that can deliver the involved clinical services while at the same time helping to “carry the banner” of providing information, modeling, skill-sharing, coaching and encouragement to their teammates for the EBP they are championing.



***From the Field:*** IDDT implementation at our agency has benefited from the concept of multiple tiers of training / expertise, molded per each staff position’s scope of practice. For example, our receptionists need not be expected to know how to facilitate a Dual Diagnosis treatment group – however, they do need to meet the expectation of knowing when and where those services are offered. All of our Case Managers may not be expected to know how to conduct a urine drug screen, but they are expected to know that this service exists, and how to help a client gain access to this and other co-occurring addictions treatment services. Our therapists are not expected to prescribe *Antabuse* or *Revia*, but they are expected to know that these pharmacological options

exist as one of a number of possible tools that can aid a client's dual recovery, and they would be expected to knowledgeably participate in discussions with prescribing psychiatrists to arrive at an informed decision about whether to include such an intervention in a client's service plan.

The second strategy involves taking advantage of competency and practice areas that may overlap between the various EBPs. The SAMHSA website features toolkits on several of the evidence-based practices that have been identified as desirable for implementation. Each of these toolkits typically includes a fidelity measure by which implementation of that particular EBP can be supported in a manner that has the best chance of being effective. **However, even a cursory overview of the various EBP Fidelity Scales reveals that there are areas of emphasis and practice common to more than one EBP.** For example, the Fidelity Scale for Assertive Community Treatment (ACT) addresses dimensions of providing treatment for co-occurring addictive disorders that dovetail nicely with dimensions of the Integrated Dual Disorder Treatment (IDDT) Fidelity Scale. As a result, ACT teams have additional incentive to pursue and master IDDT competencies, which will improve the quality of service with both the ACT and IDDT initiatives. Being aware of these overlapping areas can help agencies implement multiple EBPs more effectively and efficiently. Additionally, there are likely to be any number of overlapping practice opportunities between different EBPs that can be taken advantage of with sufficient awareness and planning, to the benefit of involved consumers.



***From the Field:*** An example at our agency involved a nice overlap between our IDDT and FPE service delivery. Having established a Dual Recovery Speakers' Bureau as part of our IDDT service implementation, we have been able to have dually recovering consumers guest-present at Family Psychoeducation groups by telling their recovery stories and providing information and perspective for the benefit of the participating FPE clients and their family members.

## 4.5 Keep On Communicating!

Effective Project Managers and Clinical Supervisors of EBPs need to possess and exercise a healthy level of assertiveness when it comes to communicating with the organization's administrative personnel, especially when it comes to advocating for needed resources. Despite the best of good intentions, and perhaps a global understanding of what is required for EBP implementation, many administrators may lack a more detailed, working knowledge of the requisite resources and necessary changes. Even though administration may have agreed to the work plan developed following the resource and barriers assessment, when the time comes to implement the planned solution, they may continue to need repeated or additional explanation about why and how the solution is being implemented.



### **Tip:**

*It is highly recommended that the assumption NOT be made that administration level personnel automatically know what is required, but rather, that clear and accessible communication channels be established, and regularly used.*



**From the Field:** *One example of working with administration from our system occurred when it became clear that the involved duties of the newly established IDDT Coordinator role required more than the half-time position that was originally dedicated to serve this function. Through efforts of assertive and informed advocacy, organization administration was approached with the request to dedicate a full-time position to the significant amount of involved work, a request that was approved. The request was granted in large part because the IDDT Coordinator made the request to expand his position through a detailed proposal that included time studies, links to the*

organization strategic plan, and recommendations about how this staffing change would bring about cost savings.



**Tip:**

*There is a useful project management perspective that represents the trade-offs that typically occur between the **QUALITY, COST, and TIME** needed for any endeavor, with the truth that to “go low” on any one of these three dimensions automatically means that the other two will be negatively impacted. For example, to accomplish a project very quickly (low **TIME**) often means that the **COST** will be high and the **QUALITY** compromised, just as to accomplish a project inexpensively (low **COST**) often means that it may take an extended period of **TIME** if it is to be of sufficient **QUALITY**. These trade-offs become visible depending on the approach taken by an organization in the implementation of EBPs.*

Take the time to build in fidelity checks and a supervision plan that promotes good clinical practice for each of the evidence-based practices. This plan needs to support ongoing quality improvement efforts. If possible, minimize the number of outcome measures that clinicians need to track by examining if there are common outcomes that each of the evidence-based practices hopes to achieve. The measures that your organization decides to use should ideally be incorporated into the ongoing recording activities of staff and the quality improvement activities of the organization.



**From the Field:** *We rated the ACT teams using the Dartmouth ACT Scale (DACTS) in 2001, at about the same time we were starting our agency’s first FPE. We used the DACTS to: 1) measure the program’s fidelity to the ACT model and therefore see where we were falling short of the ideal standard; 2) to show administration that*

*although we were not an ideal team, that we were performing as close to the model as we could with the resources we had; and 3) to encourage staff to integrate programming – such as IDDT – that would get us closer to the ideal model. We had a relatively high score for a program with no co-occurring or vocational programming, and we used the results to argue for a modest increase in resources. The DACTS gave us a standard to strive for, and staff were motivated to achieve higher fidelity and provide better services for our clients, who clearly had unmet needs. In 2005 we had the ACT Center at Purdue University come to our program and rate our agency’s 2 ACT teams using the same DACT Scale. The scores of both teams rose in comparison to 2001, because of the addition of the IDDT and FPEs evidence-based practices elements. (Although FPEs are not specifically rated by the DACTS, the presence of these groups helped boost other scores). The increased scores provided a morale boost and an acknowledgement that everyone’s hard work was paying off. But the Purdue Rating also carried new recommendations. We subsequently organized mini-retreats for both teams separately to consider how each team wanted to approach the recommendations, to try to improve the scores even more.*

Focus on what is working and what still needs to be addressed on a regular basis. Using a work plan with a timeline for each step of the implementation process for each of the evidence-based practices can help you to monitor how well the implementation is going and whether you need to revise your plan to support the success of the implementation effort. Again, do not be surprised that even with your best planning efforts, the work plan and timelines will need to be revised several times – after all, new and innovative practices typically do not come with an exact recipe for implementation, particularly since each organization has unique characteristics that must be taken into account.



**Tip:**

*Remember to continue to assess barriers and build consensus, in an ongoing fashion.*



***From the Field:*** In 2002 our organization’s IDDT implementation efforts began with an assessment of barriers (with proposed solutions) solicited from administrators, clinical staff, consumers and family members. The assessment of gaps and “growth areas” for ongoing improvement has been a regular, built-in part of our process since that time, with annual evaluations that then inform the next year’s targets for advancing the progress of IDDT implementation. Assessment of BOTH systems elements AND individual personnel competencies are important, and there are available instruments of sufficient quality that we found useful. Our organization’s initial Dual Disorder treatment “launch” phase benefited from the use of Minkoff & Cline’s COMPASS and CODECAT instruments, while we are currently utilizing SAMHSA’s IDDT Fidelity Scale to inform our forward movement during the current phase of more advanced implementation.



***Tip:***

***Remember you are implementing evidence-based practices in a “real world” setting and your best-laid plans may become ineffective and in need of adjusting because of issues outside of your control.***

Be sure to keep staff who are not involved in the implementation of specific evidence-based practices informed about the implementation process, both successes and breakdowns. Each EBP needs to be integrated into the day-to-day life of the organization, and viewed by all staff as important. ***What are the most effective ways to communicate to all staff about the implementation plans in your organization?*** It is best to try to use current systems already in place for communicating with staff. For example, if your organization has a staff newsletter, then you might include an update in each edition about evidence-based practices implementation. You may also decide to send weekly or monthly e-mail communications to all staff about the implementation

process, or you may find that posting an update in a common work area might be a more effective way of reaching a greater number of staff. In your communications, note successes in the implementation as well as acknowledging challenges that staff are experiencing in delivering these interventions. You might also identify next steps so that staff are aware of any changes in their workload or schedules based on the next phase of implementation. This ongoing provision of information supports ongoing barriers assessment and consensus building.



***From the Field:*** *Early on during our organization’s IDDT implementation efforts, it became clear that keeping service-providing staff involved and informed was an important element. This element was addressed through monthly IDDT Peer Supervision meetings, training events, individual supervision appointments, and e-mail updates sent on an as-indicated basis to our core IDDT practitioner group. However, given the thorough integration and “culture change” aspects of IDDT implementation, our staff communications needed to also cover the entire organization workforce. This level of communication was largely addressed by communications through the existing supervisory reporting network, whereby Supervisors could be informed of developments and updates via e-mail and in Supervisors’ Meetings, and then disseminate information in team meetings, individual supervision sessions, and by telephone or e-mail when deemed appropriate.*

*A similar “two-tiered” approach was also taken with regard to staff training efforts. The core IDDT Practitioner group was provided with opportunities for both internally and externally provided training, to bolster competencies necessary to deliver group and individual IDDT services. Again, given the thorough integration and “culture change” aspects of Dual Disorder treatment implementation, other organization personnel were also provided with a more basic “IDDT 101” level of orientation and training, in support of appropriately welcoming, recognition-sensitive, and treatment-referral-capable interactions with dually disordered consumers.*



**From the Field:** ACT teams were informed about the FPE groups and IDDT developments during team meetings, site meetings (where multiple teams would come together), and the Quarterly Report, in which rates of group participation are recorded. During team meetings the results of FPE efforts are discussed, and team members are often assigned to help clients carry out plans made during the FPE. Members of the ACT team who started the first FPE also attended the annual International ACT Conference to report on their initial results, practicing their presentation first to the team before the conference. Having ACT represented by team members at such a prestigious conference boosted the morale of the entire unit.

In team meetings the Substance Abuse Specialists on each ACT team present their views on problems confronting substance-involved clients, including teaching team members about co-occurring issues and how to use motivational techniques. This year we have been sending staff without the substance abuse specialty to Motivational Interviewing training offered within the organization, and have also scheduled our organization's Co-Occurring Disorders Treatment Coordinator to come to our site for regular addictions-informed supervision and training. Supervisors should also keep urging staff to feel confident to address co-occurring issues, or if unsure to ask for help from the S/A Specialist on their team.

After the ACT teams had been conducting both FPE and IDDT groups for a few months, the staff leading the groups started to report that while the content of the groups was usually different (although not always) they were trying to use similar engagement and motivational techniques to try to get clients to commit to change plans and carry them through. This was viewed as having a positive influence on working with clients outside of the groups as well.

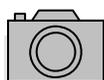
Members of the ACT teams have also attended telephone supervision sessions with Dr. David Mee-Lee. Difficult co-occurring clients have been presented and discussed in those sessions, with helpful recommendations brought back to the teams. All of the

above efforts have contributed to a beneficial cross-pollination of the evidence-based practices of ACT, FPE and IDDT.



**Tip:**

Another key base that needs to be covered during this phase is for those serving as coaches to be easily accessible to the staff who are implementing the interventions, and to key stakeholder groups. Develop power-point presentations and brief summary sheets that describe the key components of evidence-based practices for different target audiences, and continue to attend meetings within the organization and in the community to promote the evidence-based practices.



**From the Field:** For a number of clinicians at our organization, especially those relatively new to these types of integrated practices, confidence in their ability to deliver quality treatment was an issue. To address this, our organization's Co-Occurring Disorders Treatment Coordinator adopted a practice of being as immediately available / accessible as possible so that staff felt free to contact him at any time for consultation, coaching, or support. Whether by cell phone, office telephone, or e-mail, many of our organization's IDDT-providing personnel took advantage of this avenue to quickly address whatever question or obstacle was at hand, to be able to proceed with confidence. From a professional development standpoint, this practice was also viewed as fruitful as it took advantage of "optimally teachable moments" to equip staff with needed knowledge that they would likely retain longer than if simply read out of a book, or encountered in a classroom / training setting.

The implementation phase of multiple EBPs may last from one to three years or longer, depending on the complexity of each evidence-based practice being implemented. The integration of multiple evidence-based practices over time requires coordinated planning and ongoing education across the organization, on numerous levels.

## ***5.0 Sustaining the Evidence-based Practices***

An important aspect of implementing any practice is to know where you are in the process as you move toward the goal of full integration. If a clear plan for implementation is not spelled out, tracked, and completed, EBP work groups run the risk of turning into standing committees, trapped in an unhelpful focus on ongoing processes instead of accomplishing the goal of fully integrated practices. The project work plan is the score card the implementation work group uses to chart progress. Most organizations have a Quality Improvement Committee responsible for charging work groups to complete certain projects. Implementing evidence-based practices should not be considered an ongoing never-ending process, so by definition, work groups are time-limited. While the practice may change as new research informs its application, and the programs providing the service may need to update certain processes as fidelity is monitored, at some point the organization needs to be able to say that the practice at hand is integrated into the service array. Reaching that point, however, is not a time to relax. Keeping fidelity and sustaining ongoing quality improvement is the next big challenge. The organization needs to remain focused on the important task of ensuring that each of the evidence-based practices will continue to be delivered with integrity.

### ***5.1 Monitor and Support Ongoing Fidelity***

One way in which model fidelity can be maintained, and integration of multiple evidence-based practices be monitored, is to transition the EBP work group into an existing committee or team that (a) monitors the practices, (b) develops work plans to address issues that arise, (c) secures needed funding for ongoing resource needs, (d) develops training, (e) develops clinical practice guideline materials, and (f) tracks fidelity and outcomes relevant to the EBPs. This team needs to have representation from each of the evidence-based practices that have been implemented. Such a team can review and fine-tune EBP work plans in order to foster outcomes that promote improved

services for consumers and families. The team needs to receive regular updates on the implementation process for each evidence-based practice. The team should address such staff issues as ongoing professional development training, staff turnover, new hires, and changes in workloads. It is important for the team to provide systematic feedback to administrators and other staff on the successes and challenges the organization continues to face in their sustainability efforts.



**Resources:**

***In addition, you may want to incorporate flowcharts to capture the processes by which high quality EBP service delivery can be maintained. An example of a flowchart for FPE is located in APPENDIX F.***

## **5.2 Provide Ongoing Training and Supervision**

Another critical area that needs to be maintained is ongoing training and supervision for each evidence-based practice. Having key staff who were initially trained and supervised by EBP experts begin to train other staff in one or another EBP is one way to ensure ongoing quality. Developing an employee-reward structure that promotes receiving training and supervision in evidence-based practices is recommended. Don't forget to incorporate in your organization's core training programs an introduction for all staff to the different evidence-based practices being implemented. Although the public-sector, unionized arrangement of many organizations does not easily lend itself to merit raises or performance bonuses, there are still ways in which staff efforts can and have been recognized. From simple "thank you" communications, to handing out certificates of accomplishment, to complimentary e-mails (always with a "cc" to direct Supervisors), many of our organization's staff have responded positively to their work being recognized and appreciated in some manner. Staff with significant EBP achievements have also been nominated for county-wide recognition, as well as having opportunity to

attend or even present at regional, State, or national conferences as acknowledgement of their leadership and a “job well done.”



***From the Field:*** *In the summer and fall of 2005, with both ACT teams running well-established IDDT and FPE groups, and other clinics in the organization also having success with groups, it became evident that the next challenge was to figure out how to maintain this significant achievement. In order to keep these treatment modalities alive, we needed trainers, support and supervision for the groups that had been established. So far the organization has found funding to pay for a Coordinator position for IDDT services who is available for training CSTS staff in IDDT group facilitation, Motivational Interviewing and other competencies, as well as coordinating a local Dual Recovery Speaker’s Bureau, a weekly public Co-Occurring Disorders Education Lecture series, and the launch of area Dual Anonymous Recovery Groups.*

*FPE has struggled for lack of a similar senior staff coordinator position sponsored by the organization. The two senior clinicians (team Supervisors) who helped start groups have full-time duties running their programs (ACT and Supported Living / Residential units) and do not have time to train the entire staff of CSTS. These two Supervisors have provided training for their respective staff groups by sending them to conferences, and via some telephone supervision opportunities with Dr. McFarlane (in 2005). Because of looser supervision, several groups were operating with poor fidelity prior to taking the steps to formally assign a Family Psychoeducation coordinator function.*

It is also important to continue to focus on maintaining fidelity at ACT while also looking at the organization’s fidelity to IDDT, FPE, and any other EBPs that will be implemented in the future. To that end, the authors of this manual are proposing ongoing infrastructure and practice changes that will allow for the rating of evidence-based practices, using the DACTS for ACT, the IDDT Fidelity Scale, and the FPE fidelity and

outcome measurements in similar ways. We have proposed that our electronic client record be modified to record data necessary to rate a team on each and every one of the domains that are cross-walked between the various EBP fidelity scales.

### **5.3 What About Client Outcomes?**

All of the evidence-based practices recommended by SAMHSA share a common, primary goal, namely, to improve the well-being of consumers. This raises the necessary question of how such improvement on the part of consumers is to be measured – how do we know that one or more evidence-based practices are actually contributing positively to our clients' well-being? Answering this critical question requires that we measure meaningful outcomes, in order to be able to tell how well high-fidelity implementation of EBPs actually contributes to client well-being. This feedback will, in turn, provide agencies and other stakeholders with the information needed to do informed analysis, and to make associated decisions about such issues as expansion, continuance, and ongoing support for sustaining multiple evidence-based practices.

When considering the measurement of meaningful consumer outcomes, there is certainly an individualized and subjective aspect that warrants attention. Attempts at measuring this element usually take the form of a Client Satisfaction Survey. But there is also a more global and objective aspect to measuring meaningful client outcomes, that has been informed by SAMHSA's ongoing work toward establishing **National Outcome Measures** (NOMs), which are listed as follows, and outlined in the table below:

- 1) **Abstinence from drug use and alcohol abuse**  
Decreasing symptoms of mental illness and improved functioning
- 2) **Resilience and sustaining recovery**  
Getting and keeping a job or enrolling and staying in school
- 3) **Resilience and sustaining recovery**  
Decreased involvement with the criminal justice system
- 4) **Resilience and sustaining recovery**  
Securing a safe, decent, and stable place to live

- 5) **Resilience and sustaining recovery**  
Social connectedness to and support from others in the community such as family, friends, co-workers, and classmates
- 6) **Increased access to services for both mental health and substance abuse**
- 7) **Retention in services for substance abuse or decreased inpatient hospitalizations for mental health treatment**
- 8) **Quality of services provided**  
Client perception of care
- 9) **Quality of services provided**  
Cost-effectiveness
- 10) **Quality of services provided**  
Use of evidenced-based practices in treatment

DOMAIN	OUTCOME	MEASURES		
		Treatment		Prevention
		Mental Health	Substance Abuse	Substance Abuse
1. ABSTINENCE	Abstinence from drug/alcohol use	N/A	Reduction in/no change in frequency of use at date of last service vs date of first service	30-day substance use (non-use/reduction in use) Perceived risk of use Age at first use Perception of disapproval
	Decreased mental illness symptoms	Under development	N/A	N/A
2. EMPLOYMENT / EDUCATION	Increased / retained employment or return to school	Profile of adults by employment status & of children by increased school attendance	Increase in/no change in # of employed or in school at date of last service vs first service	ATOD suspensions & expulsions; workplace AOD use & perception of workplace policy
3. CRIME AND CRIMINAL JUSTICE	Decreased criminal justice involvement	Profile of client involvement in criminal & juvenile justice systems	Reduction in/no change in # of arrests in past 30 days from date of first service to date of last service	Drug-related crime; alcohol-related car crashes & injuries
4. STABILITY IN HOUSING	Increased stability in housing	Profile of client's change in living situation (including homeless status)	Increase in/no change in # of clients in stable housing situation from date of first service to date of last service	N/A

DOMAIN	OUTCOME	MEASURES		
		Treatment		Prevention
		Mental Health	Substance Abuse	Substance Abuse
5. ACCESS / CAPACITY	Increased access to services (service capacity)	# of persons served by age, gender, race and ethnicity	Unduplicated count of persons served; penetration rate – #s served compared to those in need	# of persons served by age, gender, race & ethnicity
6. RETENTION	Increased retention in treatment – sub abuse	N/A	Length of stay from date of first service to date of last service Unduplicated count of persons served	Total # of evidence-based programs & strategies
	Reduced utilization of psychiatric inpatient beds – mental health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days	N/A	N/A
7. SOCIAL CONNECTEDNESS	Increased social supports / social connectedness	Under development	Under development	Under development
8. PERCEPTION OF CARE	Client perception of care	Clients reporting positively about outcomes	Under development	N/A
9. COST EFFECTIVENESS	Cost effectiveness	# of persons receiving evidence-based services / # of evidence-based practices provided by the State	# of States providing sub abuse tx services w/in approved cost per person bands by the tx type	Increase services provided w/in cost bands w/in universal, selective, and indicated programs
10. USE OF EBPs	Use of evidence-based practices		Under development	Total # of evidence-based programs and strategies

Improvement in any and all of these domains is the common goal of each and every evidence-based practice – indeed, in a real sense it should be the goal of ALL of our service delivery. It comes as no surprise that the SAMHSA toolkits available for each of the evidence-based practices have in them a common “Client Outcomes – Quarterly Report Form” intended to gather this valuable and informative data. Use of this, or some similar outcome measurement tool or process is essential in order to be able to know, and demonstrate, that the implementation of one or more EBPs is having the desired effect.

## Evidence-Based Practices: Shaping Mental Health Services Toward Recovery Client Outcomes – Quarterly Report Form

Client ID: _____	Reported by: _____
Date: _____	Quarter: _____

*Indicate the client's status during the past 3 months. Check all that apply:*

Evidence-Based Practice	Eligible	Enrolled
Integrated Dual Disorders Treatment		
Supported Employment		
Assertive Community Treatment		
Illness Management & Recovery		
Family Psychoeducation		

*In the **past 3 months**, how many weeks has the client:*

Held a competitive job?	
Been homeless?	
Been incarcerated?	
Been hospitalized for psychiatric reasons?	
Been hospitalized for substance use reasons?	

*What has been the client's stage of substance abuse treatment during the **past 3 months**? Circle one.*

N/A	Engagement	Persuasion	Active treatment	Relapse prevention
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*What is the client's **current** living arrangement? Circle one.*

1. Psychiatric hospital 2. Substance use hospitalization 3. General hospital psychiatric ward 4. Nursing home or IC-MH 5. Family care home 6. Lives with relatives (heavily dependent for personal care) 7. Group home	8. Boarding house 9. Lives with relatives (but is largely independent) 10. Supervised apartment program 11. Independent living 12. Other (specify) 13. Emergency shelter 14. Homeless
--	---

*What is the client's **current** educational status? Circle one.*

1. No educational participation 2. Vocational / educational involvement 3. Pre-educational explorations 4. Working on GED 5. Working on English as second language 6. Basic educational skills	7. Attending vocational school or apprenticeship, vocational program (CNA training) or attending high school 8. Attending college-1-6 hours 9. Attending college -7 or more hours 10. Other (specify)
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Organizations attempting to implement multiple EBPs are optimally positioned to be able to ascertain “what works” for their consumers if they have and use such outcome measurement capability. Making such information available to clinicians and other stakeholders can help to maintain ongoing support and a high level of morale for the continuance of EBPs if the data is encouraging. Even if outcome data does not meet expectations, it still has tremendous value for making any indicated adjustments that may improve efficacy. In a sense, this represents the embedding of an agency’s own “evidence base” with which to evaluate the impact of changes in any and all practices.

#### **5.4 EBP Outcomes, Fidelity, and Electronic Health Records**

With the increasing use of Electronic Health Records, provider agencies are being equipped with incredibly powerful tools, the potential of which is still being realized. Nowhere is this more significant than in the area of data collection that is sufficiently detailed, meaningful and immediately available for use in monitoring and supporting EBP fidelity, and for evaluating outcome efficacy. Operationalizing both the EBP Fidelity Scales found in the SAMHSA Toolkits as well as meaningful outcome measures represents, perhaps, one of the next great developments in the implementation, quality assurance, and sustainability of multiple evidence-based practices. It is only a matter of time before this technology is able to serve consumer, provider, and stakeholder alike with the provision of real-time data that indicates in meaningful fashion whether or not EBPs are being properly implemented and maintained, and what outcomes there are to show for these efforts.



***From the Field:*** Although our agency has had an electronic health record for several years now, we are still in the process of making adjustments to build in decision-support for clinical staff, and to allow for the documentation of data in ways that both support EBP implementation, and provide what is needed to evaluate EBP outcomes efficacy. For example, with IDDT services an electronic record can be designed such

that the Progress Note of every contact with a client known to have a Substance Dependence diagnosis can prompt the staff person to ask about the current status of that client's relationship with the identified substance. That client may be at one or another Stage of Change / Treatment with regard to dealing with their substance use, but prompting staff to interact around that issue is what provides the treatment team with the information necessary to tailor treatment in a stage-wise manner to best meet that client where they are at, and most effectively deliver services in a manner that has the best chance of moving that client along toward greater progress in recovery.



***Resources:***

Following the ***Appendices*** and ***References*** at the end of this chapter, we have listings of ***Additional Resources***, ***Helpful Databases and Search Engines***, ***Web Journals*** and ***Web Publications*** that may be of benefit to your efforts to implement and maintain multiple EBPs.

Remember, your organization is constantly changing and new evidence-based practices are continuing to emerge. It is a continuous process and one that requires you and your organization to be flexible and responsive to emerging practices. Always remember the movement to change is difficult and that you and your organization are making a difference for consumers and families.

We wish you all the best in this worthwhile endeavor . . .

## 6.0 Appendices

- 6.1 APPENDIX A: *The Community Mental Health Partnership of Southeastern Michigan (CMHPSM) Policy and Procedure for Approval and Implementation of New Programs*
- EXHIBIT I – Balanced Scorecard Alignment Guide
  - EXHIBIT II – New or Revised Program, Project, Service or Key Work Process Proposal Format
  - EXHIBIT III – Project Proposal Evaluation Template
  - EXHIBIT IV – New Initiative Approval Sample Flowchart
- 6.2 APPENDIX B: Integrated Dual Disorder Treatment (IDDT) Implementation Barriers and Solutions Work Sheet
- 6.3 APPENDIX C: IDDT Implementation Steps Taken By Washtenaw County CSTS
- 6.4 APPENDIX D: Family Psychoeducation (FPE) Logic Model
- 6.5 APPENDIX E: Principles of Practice Examples
- Dual Disorders Treatment, and
  - Family Psychoeducation
- 6.6 APPENDIX F: Single and Multiple Family Psychoeducation Flowchart
- 6.7 APPENDIX G: Sample CSTS Quarterly Project Work Plan

## 6.1 APPENDIX A: (1 of 4)

### ***The Community Mental Health Partnership of Southeastern Michigan*** **Policy and Procedure for** **Approval and Implementation of New Programs**

#### **PURPOSE:**

Establish a process for the approval and implementation of new or revised programs, projects, services or key work processes for the Community Mental Health Partnership of Southeastern Michigan (CMHPSM) and each affiliate member.

#### **APPLICATION:**

This policy and procedure applies to all CMHPSM staff, students and or volunteers.

#### **DEFINITIONS:**

**Best Practice:** A practice that has empirical evidence demonstrating effectiveness (i.e. peer reviewed research demonstrating effectiveness) but the studies are not necessarily controlled, randomized or replicated by different investigators. The term Best Practice is subsumed in the definition of an Evidence Based Practice (see the Evidence Based Practice definition) however the terms are not interchangeable.

**Evidence Based Practice:** A practice that has demonstrated effectiveness by way of extensive, randomized research, by several different researchers (e.g. Assertive Community Treatment).

**Initiative or Project:** A clinical practice (e.g. co-occurring services) or system change (e.g. Encompass) that impacts consumers and/or staff fundamentally changing how we deliver services across the organization.

**Key process:** A series of related tasks that comprise or support a service.

**Program:** A set of services designed to meet the needs of an identified population.

**Promising Practice:** A term used to describe a practice that is on the way to becoming a best practice. The practice is in the process of being developed and few data or reports are available to describe effectiveness (e.g. only anecdotal evidence reporting effectiveness).

**Service:** A discrete program component or treatment activity.

## 6.1 APPENDIX A: (2 of 4)

### **POLICY:**

- A. The CMHPSM is committed to insuring that new or revised programs or processes support the mission and vision of the Affiliation and are aligned with key strategic goals and are well coordinated. The “CMHPSM Balanced Scorecard Alignment Guide” is a tool that can assist in insuring alignment (Exhibit A)
- B. The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is committed to providing continuous improvement in programs and processes. Continuous improvement includes an ongoing evolution of programs, services and processes.
- C. This policy establishes standards across the CMHPSM for the evaluation of proposed projects, including revising existing programs and services or developing new programs and significant changes to work processes.
- D. This policy also establishes an approach to change leadership and project management to insure that new projects are implemented effectively and address the impact on consumers, staff and other stakeholders.
- E. Proposals shall be submitted in writing and shall address all elements in the “New Initiative Assessment Guideline” (Exhibit B).
- F. All major changes in programs, services or processes shall be well managed, based on a clear vision, address the impact on consumers, staff and stakeholders and based on project or action plans following utilizing established tools and techniques. Project plans shall include a change plan, detailing changes to processes and roles and how the organization will support the initiative.
- G. The Performance Improvement Committee shall review all new or revised programs, services or key processes.
- H. All project proposals shall be evaluated based on impacts from each of the following key perspectives that may impact significant resources and or the development of uniform service delivery. Follow the “Project Proposal Evaluation Template” (Exhibit C):
  - Customer/Health & Safety
  - Learning and Growth
  - Operations and Internal Processes
  - Finance

## 6.1 APPENDIX A: (3 of 4)

- I. The Performance Improvement Committee shall approve all new or revised programs, services or key processes that do not involve significant resource allocations.
- J. For all new or revised programs, services or key processes that request significant resource allocations, the proposal will be reviewed by the PI committee with a recommendation given to the Affiliation Executive Committee (AEC) for a decision.

### REFERENCES:

CMHPSM Project Planning Toolkit

- CMHPSM Project Planning Work plan
- CMHPSM Project Matrix

CMHPSM Financial Principles

### EXHIBITS:

- A.) CMHPSM Balanced Scorecard Alignment Guide
- B.) CMHPSH New Initiative Proposal format
- C.) CMHPSM Project Proposal Evaluation Template

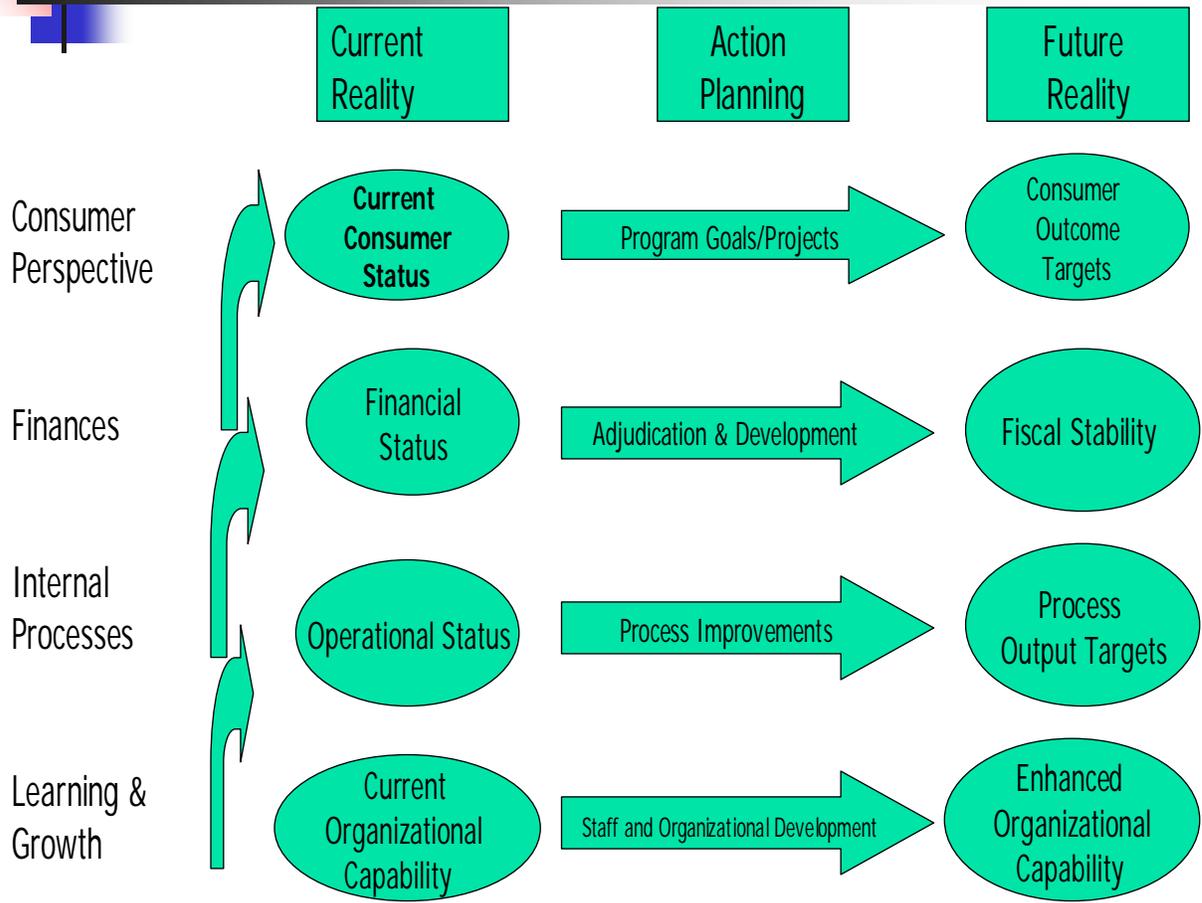
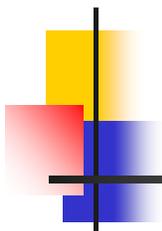
### PROCEDURE:

<u>WHO</u>	<u>DOES WHAT</u>
Staff or Committee proposing project	<ul style="list-style-type: none"> <li>▪ Develops a proposal following approved guidelines</li> <li>▪ Submits proposal to the PI Committee.</li> </ul>
Performance Improvement Committee	<ul style="list-style-type: none"> <li>▪ Reviews proposals based on key perspectives (Customer/Health &amp; Safety, Finance, Learning &amp; Growth, Operations and Internal Processes)</li> <li>▪ If proposal is deemed consistent with achievement of goals, addresses proposal in conjunction with other current plans :</li> <li>▪ Makes determination as to whether or not proposal will be implemented</li> <li>▪ Informs developer and other interested stakeholders of decision</li> <li>▪ If proposal is approved, assigns responsibility for project implementation and change leadership plan</li> <li>▪ May request additional information for the proposals for further clarification.</li> <li>▪</li> </ul>

## 6.1 APPENDIX A: (4 of 4)

- |                                       |   |
|---------------------------------------|---|
| Affiliation Executive Committee (AEC) | <ul style="list-style-type: none"> <li>▪ Notifies AEC of approved proposals.</li> <li>▪ Makes recommendations to AEC for proposals that require significant resource allocation.</li> <li>▪ Provides periodic updates to the AEC on the implementation of new programs.</li> <li>▪ Reviews funding and staff resource availability of proposals that have significant resource allocations.</li> <li>▪ Makes determination as to whether or not proposal will be implemented that require significant resource allocation.</li> <li>▪ If needed make suggested recommendations to be considered of PI approved proposals.</li> <li>▪ Receives periodic updates through PI report on implementation of new program.</li> </ul> |
| New Program Leader                    | <ul style="list-style-type: none"> <li>▪ Develops project implementation plan, including change leadership plan, following the established guideline and using recommended tools and formats</li> <li>▪ Submits implementation plan and change leadership plan to the PI Committee or designated committee for final approval</li> </ul>  |
| Performance Improvement Committee     | <ul style="list-style-type: none"> <li>▪ Approves project implementation and change leadership plan</li> <li>▪ Monitors implementation progress and outcomes at defined intervals utilizing the Project Matrix format</li> <li>▪ Provides leadership support for change as outlined in implementation plan, with particular focus on communication</li> </ul>   |

# CMHPSM Balanced Scorecard Alignment Guide



**6.1 Exhibit II – (1 of 3)**

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN  
**New or Revised Program, Project, Service or Key Work Process  
 Proposal Format**

Any that a staff member, committee, department or program desires to implement, must complete the follow proposal that address the areas identified below. The purpose is to ensure that all new implementations are done in a way that ensures all necessary elements are identified and addressed for successful implementation.

### **Overview**

Describe the proposed program, service or initiative including:

- Target population or subpopulation
- Service or activity to be delivered
- Expected outcomes and benefits

State the vision for this initiative and describe how it will advance the mission/vision of the Affiliation including how the initiative supports the advancement of:

- Affiliation Strategic Plan
- An identified element in the Strategic plan
- Governing Body Priorities
- Guiding Principles and Values
- Contractual obligations, regulatory compliance or accreditation standard compliance
- Recommendations from performance improvement

### **Customer Perspective**

*How will this initiative support excellence in customer services?*

- Is this initiative based on evidence-based practice, best practice or a promising practice? If so, please attach or incorporate references and materials to demonstrate.
- If the project is for a clinical practice, is there evidence of applicability of the practice across cultures? If not, how will this be addressed?
- Who are the primary stakeholders for this project?
- Describe stakeholder involvement in the development of this project and expected stakeholder involvement in implementation.
- Are external benchmarks available for this project?

**6.1 Exhibit II – (2 of 3)**

*How will success be evaluated?*

- What tests, measures, or analysis will be conducted to determine whether or not the project results in improvements?
- What specific outcomes will be measured?
- Are they currently embedded in ongoing data collection processes? If not, attach an indicator worksheet and data collection request.

**Learning and Growth Perspective**

*What skill, knowledge and competencies will be required to successfully implement this project?*

- For clinical practices, please be discipline-specific.

*What staff training and development will be required for successful implementation?*

- Please address learning needs at each level of the organization and across disciplines.
- Identify the resources needed and available to address learning needs.

*How will the project recognize success on the part of consumers, staff and other stakeholders?*

*What contribution to the knowledge base will be made as a result of this project, both locally and beyond?*

**Internal Processes / Operational Perspective**

Identify work process or practices that will be impacted by this project. Please address impact on clinical, support and administrative processes.

*What standards will be applied to measuring success of this project (such JCAHO, DCH, EQR, fidelity scales)?*

- Please cite specific references.

*Describe the plan for regular review and revision of the project.*

*How will technology be applied in the implementation of this project?*

- Identify any new / additional technology that will be required for success
- Identify any changes needed to existing technology
- Will specific changes to Encompass be required for implementation? If so, please describe

**6.1 Exhibit II – (3 of 3)**

*How will this initiative align with regional or other partnerships and the strategic plans or stated goals of those partnerships?*

- Describe any partnerships or collaborations between programs, departments or with external agencies that are either involved in, or impacted by implementation.

*Does this initiative incorporate findings or recommendations from performance improvement data, workgroups or processes?*

- If so, please describe or attach.

*Does this initiative incorporate any recommendations from root-cause analysis of sentinel events, adverse events or recommendations based on recipient rights trends?*

- If so, please describe.

*Are policies and procedures in place to support this project?*

- Identify any new policies and procedures that will be required or existing policies and procedures that will be modified.

*Identify any job descriptions or clinical competencies that will require updates.*

*What risks are associated with this proposal and how are they addressed?*

*What barriers do you anticipate in implementation of this initiative? How will they be addressed?*

### **Financial Perspective**

*What resources are needed including staffs, space, materials, equipment (attach budget)?*

*What is the proposed source of funding (redirection, grants, contracts, revenues)?*

*If funding source is time-limited, how will project be sustained following any grant period?*

*Please evaluate the potential return on investment (ROI) for this project.*

*Have the financial resources been assessed against the CMHPSM financial principles?*

**6.1 Exhibit III – (1 of 6)**

*Community Mental Health Partnership of Southeast Michigan*

## **Project Proposal Evaluation Template**

**Purpose:** To evaluate the potential merits and impact of a new initiative on the organization;

**Directions:** *(Please use the attached definitions when scoring the statements)*

Based on your knowledge of the CMHPSM or your CMH system and the initiative under review score the following statements and aggregate the scores for each of the three domains. Following this exercise the AEC or designated committee will aggregate the scores for the proposal. This data will be used by AEC or the designated committee in deciding whether or not to approve the proposal.

### **Categories:**

#### **1) The Consumer Perspective Criteria**

a) The initiative advances the mission, values and goals of the CMHPSM.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

b) The initiative is (circle one):

N/A	Unknown	A Promising Practice	A Best Practice	An Evidence-Based Practice	Will need to Determine
-----	---------	----------------------	-----------------	----------------------------	------------------------

c) The initiative is likely to have a positive impact on consumers, their family and the community.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

**6.1 Exhibit III – (2 of 6)**

d) The proposal demonstrates involvement of stakeholders in the development process.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

e) The proposal clearly identifies specific planned outcomes and tests, measures or analysis that will be conducted to measure success of the project.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

**Total Score:** \_\_\_\_\_

## 2) Learning and Growth Perspective

a) The proposal identifies the skill, knowledge and competencies required to successfully implement the project.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

b) The proposal identifies staff training and development needs and the resources needed and available to address learning needs.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

c) The proposal identifies how success on the part of staff, consumers and other stakeholders will be recognized.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

**6.1 Exhibit III – (3 of 6)**

d) The proposal demonstrates potential contribution to the general knowledge base in the field.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

**Total Score:** \_\_\_\_\_

**3) Internal Processes/Operational Perspective**

a) The proposal clearly identifies work processes or practices that will be impacted.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

b) The proposal identifies external standards that will be applied to the project.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

c) The proposal includes a plan for regular review and revision.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

d) The proposal describes the application of technology in the project.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

**6.1 Exhibit III – (4 of 6)**

e) The proposal identifies how the project will align with other projects, collaborations and partnerships.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

f) The proposal incorporates relevant findings from the Performance Improvement system.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

g) The proposal addresses any relevant recommendations from root cause analysis, or trends identified through the ORR process.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

h) The proposal identifies impact in each of the following areas;

- Policies and Procedures
- Job Description or clinical competencies

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

i) The proposal adequately identifies potential risks and barriers related to the project.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

**Total Score:**\_\_\_\_\_

**6.1 Exhibit III – (5 of 6)****4) The Financial Perspective**

a) The proposal clearly and adequately identifies the resources needed to implement the project including:

- Staff
- Space
- Materials
- Equipment

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

b) The proposal identifies the sources of funding for the project:

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

c) The proposal includes a sustainability plan

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

d) The proposal includes a “Return on Investment” Analysis

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

e) The proposal has included how financial resources have been assessed against the CMHPSM financial principles

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

**Total Score:**\_\_\_\_\_

**6.1 Exhibit III – (6 of 6)****Scoring:**

**Domain One (Range 2-20)**

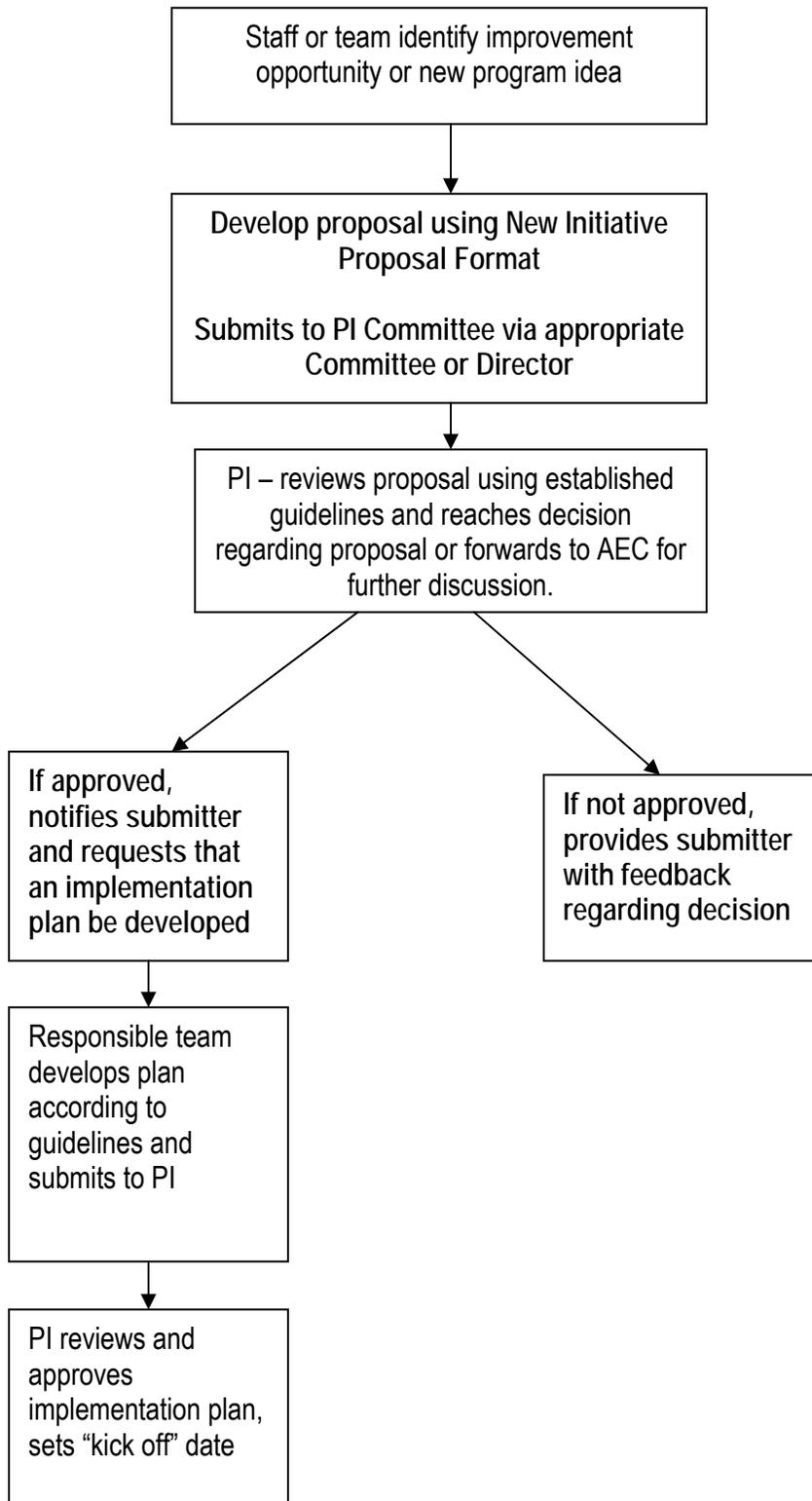
**Domain Two (Range 2-20)**

**Domain Three (Range 2-45)**

**Domain Four (Range 2-20)**

**Total of all Domains (Range 2-105)**

### CMHPSM New Initiative Approval Sample Flowchart



## 6.2 APPENDIX B: (1 of 4)

**Washtenaw County CSTS****IDDT Implementation Barriers and Solutions Worksheet**

<b>POLICY</b>		
<b>Barriers</b>	<b>Proposed Solutions</b>	<b>Required Resources</b>
Separate SA & MI funding streams	Advocate for State-approved blending options; work with CA & PIHP on creative solutions	
Payment for psychotropic medications for SA providers working with dual population	Maximization of sample meds programs; C.A.-sponsored "bridge meds" pilot program	
Policy obstacles of other community providers re: comprehensively serving SPMI co-occurring population	Collaboration with area hospital ERs, Detox service providers, Halfway house providers to support services to the co-occurring population; Develop resources to fill missing gaps in the continuum of care	
SPMI co-occurring population Policy obstacles of funders (ex. M-Care not authorizing MH treatment if there is an SA diagnosis and less clean time than 6 months)	Joint discussion and planning around high utilizers of multiple systems; consider dual diagnosis carve-in options	
Differences between MI Person-Centered-Plan & SA Treatment Plan	Find common ground / framework for addressing all needs and concerns, and provide training to staff	
Different confidentiality, recipients rights rules	Integrate / crosswalk CFR 42, Michigan Mental Health Code, and HIPAA for greatest protection of confidentiality, & greatest helpful consumer access to treatment records	

## 6.2 APPENDIX B: (2 of 4)

<b>IDDT Implementation Barriers and Solutions Worksheet</b>		
<b>PROGRAM</b>		
<b>Barriers</b>	<b>Proposed Solutions</b>	<b>Required Resources</b>
Need for workable service model	Minkoff training & consultation	
No "new" funding	More clinically efficient use of current resources; maximization of grant funding opportunities	
Staff maxed out with current workload	Engage staff in the vision that with more effective tools, their work will be more efficient	
The threat of more paperwork	Streamline and integrate required documentation	
Psychiatrists reluctant to include SA diagnoses	Provide treatment option to cover liability concerns; Support MD-to-MD training; Consistently connect Assessment-Diagnosis-Treatment-Outcomes	
Need for Quality Assurance	Utilize existing measures (COMPASS, CODECAT, IDDT Fidelity Scale), or develop own to monitor implementation and outcomes	
Need for Drug Testing options with supporting policy and practice protocols	Develop and implement staged roll-out plan, cross-train across organization, AND community (PES, ACCESS, PORT, law enforcement, etc.)	
Need to integrate across multiple departments	Collaborate to fill gaps with providers and Coordinating Organization; Develop resources / services to fill gaps	
Continuum of care for co-occurring consumers is lacking	Collaborate with stakeholders to develop these pathways (CSTS jail staff, Street Outreach Court)	
Need jail diversion / drug court options	Collaborate with stakeholders to inform, develop or import programming, training	
Lack of IDDT in Nursing Homes		

## 6.2 APPENDIX B: (3 of 4)

<b>IDDT Implementation Barriers and Solutions Worksheet</b>		
<b>CLINICAL</b>		
<b>Barriers</b>	<b>Proposed Solutions</b>	<b>Required Resources</b>
Mixed "buy-in" to integrated services	Organization commitment to acknowledging the need, and treating the total person; leadership vision	
Common clinical framework missing		
Existing service gaps		
Need common assessment tool(s)	Ongoing commitment to Minkoff, Drake, Mee-Lee, others (SAMHSA, etc.) to inform clinical service design/delivery	
Treatment needs to be individualized	Analyze need along 4-Quadrant continuum, maintain linkages, & work on filling gaps, including engagement, detox ("to sub-acute from ER" option), housing resources	
Psychiatrists not IDDT-informed	Pursue or develop, along with associated training	
Staff need training	Utilize Stages-of-Change and Stages-of-Treatment perspectives to match consumers appropriately	
	Provide training, tools (Rx protocols) from Minkoff, others	
	Provide training, incentivize CAC achievement, collaborate with C.A. and SA provider community	
Lack of recovery-supportive housing options	Collaborate and fill gaps, including emergency housing, ½-way house & ¾-house options, damp housing flexibility (10-Year-Plan venue, IDDT D-IOP development)	
Multiple CSTS provider sites information about resources	Coordinate services, with Encompass (web-based database consumer record) support	
Lack of community support,	Support Dual Recovery Anonymous development & links with recovering community; provide staff with recovery resource information	
Need for transportation for consumers to get to treatment / support appointments	Provide some staff transportation resource as part of case management; facilitate networking within consumer and recovery communities	
Sporadic attendance at dual group	Tier services to fit stage-of-change (Discovery AND Recovery services)	
Limited group & didactic material	Purchase, develop pertinent resources	

## 6.2 APPENDIX B: (4 of 4)

<b>IDDT Implementation Barriers and Solutions Worksheet</b>		
<b>CONSUMER / FAMILY</b>		
<b>Barriers</b>	<b>Proposed Solutions</b>	<b>Required Resources</b>
Concern re: increased resistance to IDDT by consumers	Include Motivational Enhancement strategies for change	
Need for family education	Facilitate weekly Co-Occurring Education Lecture series & invite stakeholders	
Need for addiction-informed psychiatrists	Continue to education psychiatry staff; develop consulting connection with ASAM-trained psychiatrist	
Stigma concerns, including within AA, NA	Educate and share successes; develop DRA (including DRA meeting at local Alano Club)	
Jail diversion needed	Develop effective diversion pathways	
Police need training for more effective intervention	Collaborate with law enforcement to offer training, and as needed case-by-case	
Need staggered treatment/support groups for day-shift workers	Offer evening / weekend programming and support hours and options (CSTS groups, DRA meetings)	
Need more group options re: day of week, times, locations	Expand programming to maximize access opportunities (13 staffed groups per week)	
Denial, confusion, lack of motivation about dual disorders	Educate, utilize Stage-of-Change framework, and Motivational Enhancement strategies	
Need for employment	Collaborate with MRS, other vocational service providers	

## 6.3 APPENDIX C: (1 of 3)

### Washtenaw County CSTS Dual Disorder Treatment Implementation Sequence

<b><u>2002</u></b>	
Agency conducts extensive stakeholder meetings to identify resources and barriers [See APPENDIX B]; Also consults with Dr. Kenneth Minkoff, and Dr. Robert Drake, for direction re: implementation efforts.	<b>June- December</b>
<b><u>2003</u></b>	
Agency gains temporary Substance Abuse Treatment License as a provider of outpatient and prevention services at 5 provider sites	<b>Jan</b>
Agency submits provider application to local Substance Abuse Coordinating Agency to join SA provider panel	
Staff competency requirements updated for all disciplines to reflect co-occurring competencies – 20 staff identified with appropriate billable credentials, experience and interest to participate in service provision	<b>Feb</b>
Administration approves pay grade advancement incentive for Bachelor's-level Case Managers who obtain the Certified Addictions Counselor credentialing	
Agency begins to offer free, weekly Co-Occurring Disorders Education Lectures open to consumers, family members, friends and professionals	<b>March</b>
Number of co-occurring treatment groups grows from four to nine weekly groups at seven sites (both office-based and community-based)	
Permanent Substance Abuse Treatment License granted to Agency by the State of Michigan's Office of Substance Abuse Licensing	<b>April</b>
CSTS offers 4 adolescent / family educations groups at the Child and Family service site	<b>May</b>
Agency is approved to join local SA Provider panel, and contract extended to receive referrals and treatment service reimbursement from Substance Abuse funding stream	<b>June</b>
Agency assists in the launch of the county's first Dual Recovery Anonymous meeting	<b>July</b>

## 6.3 APPENDIX C: (2 of 3)

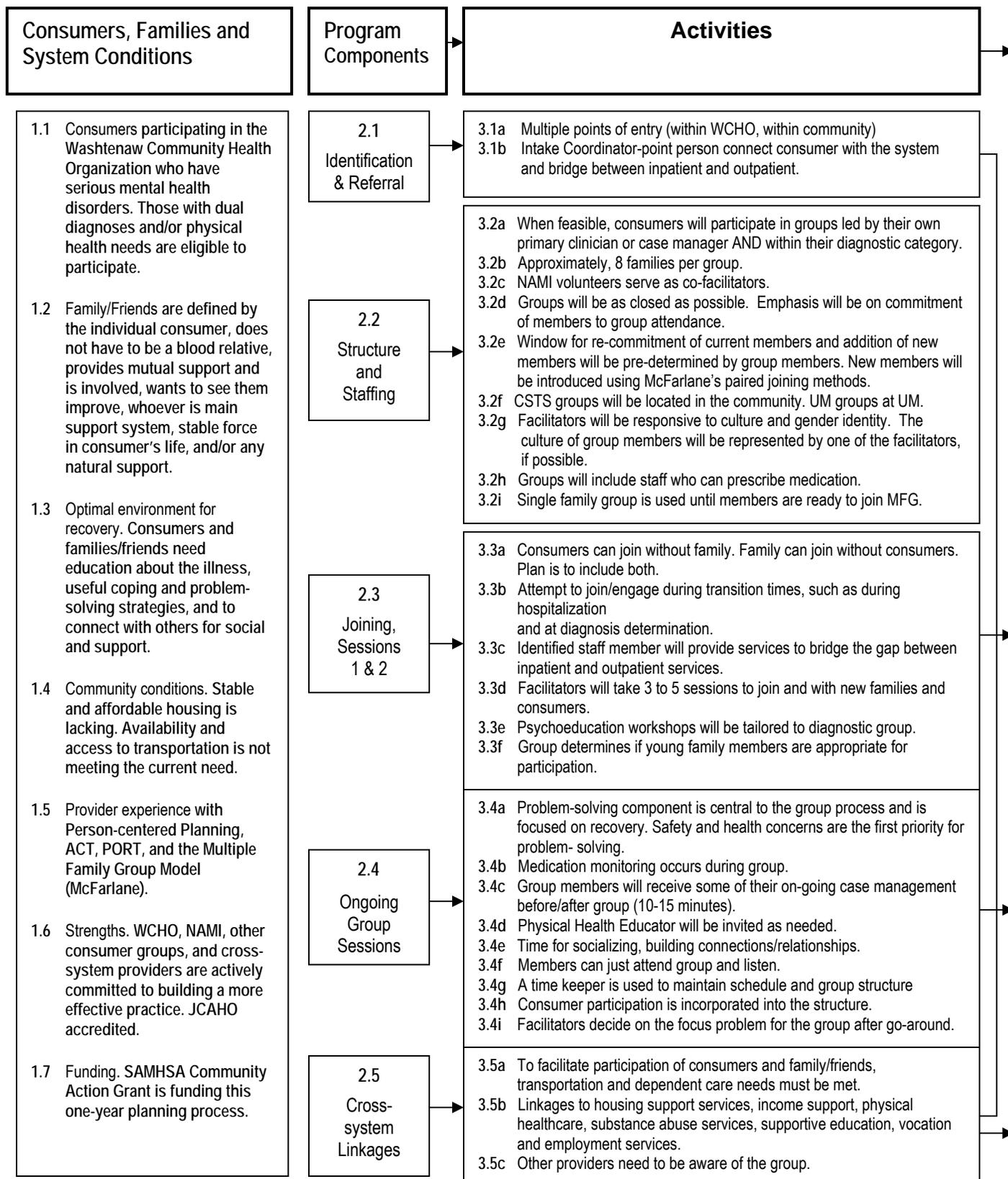
Agency clinical documentation forms developed or adjusted to better support Dual Disorder treatment services delivery (Initial Assessment, Progress Note, Health Review) including identification of Stage of Change, ASAM domain status, and spirituality assessment	<b>August</b>
Staff training and Clinical Supervision provided in ongoing manner including (but not limited to): <ul style="list-style-type: none"> <li>• Substance Abuse Confidentiality and Recipients Rights</li> <li>• Minkoff model of Co-Occurring treatment</li> <li>• ASAM criteria / Dimensions of Care (Mee-Lee)</li> <li>• IDDT Treatment Planning (Mee-Lee)</li> <li>• HIV / AIDS training for SA providers</li> <li>• Motivational Interviewing</li> <li>• SA Referral, Authorization &amp; Utilization Review</li> <li>• Monthly Peer Supervision meetings</li> <li>• Clinical supervision and CAC coaching</li> <li>• Resource materials at each CSTS site (hard-copy), on staff-accessible computer network, and at a centrally located video library</li> </ul>	<b>September</b>
	<b>October</b>
	<b>November</b>
	<b>December</b>
<b><u>2004</u></b>	
Participation in monthly Regional Affiliation Dual Disorders Workgroup meetings continues to occur	<b>Jan</b>
	<b>Feb</b>
The agency's JCAHO accreditation was expanded to include SA services	<b>March</b>
The number of consumers receiving Dual Disorder treatment Services during first "official" year as a Dual-Enhanced provider exceeds 150	<b>April</b>
Number of co-occurring treatment groups grows from nine to thirteen weekly groups at seven sites (both office-based and community-based)	<b>May</b>
	<b>June</b>
COMPASS and Modified CODECAT administered annually to assess agency progress and clinician competencies, as part of Regional Affiliation EBP Work Plan	<b>July</b>
	<b>August</b>
Substance Abuse Coordinating Agency sponsors annual training conference to support Dual Disorders treatment competencies, on the topic of "Trauma-Informed Treatment"	<b>September</b>
Nontraditional Intensive Outpatient treatment option for CMH consumers is negotiated with local Substance Abuse Coordinating Agency	<b>October</b>
	<b>November</b>
A full-time staff position is created to coordinate agency Dual Disorders treatment services development and implementation	<b>December</b>

## 6.3 APPENDIX C: (3 of 3)

<b><u>2005</u></b>	
Monthly Dual Disorders Group Supervision meetings continue to occur	<b>Jan</b>
Weekly Co-Occurring Disorders Education Lecture Series gains attendance, including agency staff seeking Certified Addictions Counselor credentialing	<b>Feb</b>
Six Case Managers successfully obtain Certified Addictions Counselor credentialing, with additional staff pursuing	<b>March</b>
Agency continues support for the launch of area Dual Recovery Anonymous meetings, 3 weekly groups now meeting, including one at the local Alano Club	<b>April</b>
	<b>May</b>
Drug testing materials purchased and tested for utility as an in-house procedure with therapeutic benefit	<b>June</b>
COMPASS and Modified CODECAT administered annually to assess agency progress and clinician competencies, as part of Regional Affiliation EBP Work Plan	<b>July</b>
	<b>August</b>
Substance Abuse Coordinating Agency sponsors annual training conference to support Dual Disorders treatment competencies, on the topic of "Motivational Engagement" Strategies	<b>September</b>
Monthly Regional Dual Disorders Workgroup meeting changes from monthly to Quarterly, with local Workgroups continuing to meet monthly	<b>October</b>
Psychiatrist training provided in support of Dual-Disorders-informed prescribing practices, and use of psychopharmacology as part of integrated service delivery	<b>November</b>
Dual Recovery Speakers' Bureau established with grant-funding support, allowing consumers to be reimbursed for sharing their Dual Recovery stories in front of various audiences	<b>December</b>

6.4 APPENDIX D:

**Family Psychoeducation Logic Model: WCHO Initiative**



## 6.5 APPENDIX E: (1 of 6)

# SERVICE PLANNING GUIDELINES / PRINCIPLES OF PRACTICE

## CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS TREATMENT

### ***Introduction***

*During the past two decades, as awareness of individuals with co-occurring psychiatric and substance disorders has increased, there has been a steady accumulation of data to permit the development of both evidence-based and consensus-based best practice models for the treatment of these individuals. These “best practices” need much more study, but they are sufficiently well developed at present that it is possible to use them to formulate coherent practice guidelines for assessment, treatment, and psychopharmacology of individuals with co-occurring disorders.*

*These practice guidelines are outlined in this document. Before delineating the practice guidelines themselves, however, it is important to describe the data-based and consensus based foundation in the literature that supports them. This evidence base incorporates the following principles (Minkoff, 2000):*

### **1. Dual diagnosis is an expectation, not an exception.**

Both the Epidemiologic Catchment Area survey (Regier et al, 1990) and the National Comorbidity Survey (Kessler et al, 1996) support the high prevalence of comorbidity in both mentally ill populations and substance disordered populations. 55% of individuals in treatment for schizophrenia report lifetime substance use disorder (Regier et al, 1990), and 59.9% of individuals with substance disorder have an identifiable psychiatric diagnosis (Kessler et al, 1996).

## 6.5 APPENDIX E: (2 of 6)

- 2. The population of individuals with co-occurring disorders can be organized into four subgroups for service planning purposes, based on high and low severity of each type of disorder (NASMHPD / NASADAD, 1998; Ries & Miller, 1993).**

In 1998, the National Association of State Mental Health Program directors and the National Association of State Alcohol and Drug Abuse Directors arrived at an unprecedented consensus to use this “four quadrant” model for service planning purposes.

- 3. Treatment success involves formation of empathic, hopeful, integrated treatment relationships (Drake et al, 1993, 2001 Minkoff, 1998).**

This principle derives from analysis of multiple program models. Integrated treatment does not imply a single type of intervention, so much as the capacity, in the primary treatment relationship, to integrate appropriate diagnosis-specific interventions for each disorder into a client-centered coherent whole, with the ability to modify interventions for each disorder to take into account the other.

- 4. Treatment success is enhanced by maintaining integrated treatment relationships providing disease management interventions for both disorders continuously across multiple treatment episodes, balancing case management support with detachment and expectation at each point in time (Drake, et al 1993; 2001 Minkoff, 1998).**

Progress is usually incremental, and no data supports a single brief intervention as providing definitive treatment for persistent comorbid conditions. The extent of case management support and structure required are proportional to the individual's level of disability and impairment in functioning.

## 6.5 APPENDIX E: (3 of 6)

### **5. Integrated dual primary diagnosis-specific treatment interventions are recommended (Minkoff, 1998).**

The quality of any integrated intervention depends on the accuracy of diagnosis and quality of intervention for each disorder being treated. In this context, integrated treatment interventions should apply evidence-based best practices (for psychopharmacology as well as for other interventions) for each separate primary disorder being addressed. In addition, a growing data set supports the high prevalence of trauma histories and trauma-related disorders in these individuals, women (85%) (Alexander, 1996; Harris, 1998) more so than men (50%) (Pepper, 1999), and there is increasing evidence of the value of trauma-specific interventions being combined with interventions for other psychiatric disorders as well as for substance disorders (Harris, 1998; Evans and Sullivan, 1995, Najavits et al, 1998).

### **6. Interventions need to be matched not only to diagnosis, but also to phase of recovery, stage of treatment, and stage of change.**

The value of stagewise (engagement, persuasion, active treatment, relapse prevention) treatment (Mueser et al, 1996; Drake et al, 1993, 2001) has been well-documented, as well as stage specific treatment within the context of the transtheoretical model of change (Prochaska & DiClemente, 1992). Minkoff(1989, 1998) has articulated parallel phases of recovery (acute stabilization, motivational enhancement, prolonged stabilization, rehabilitation and recovery) that have been incorporated into national consensus guidelines.

### **7. Interventions need to be matched according to level of care and/or service intensity requirements, utilizing well-established level of care assessment methodologies.**

## 6.5 APPENDIX E: (4 of 6)

Both ASAM PPC2 (ASAM, 1995) and LOCUS (AACP, 1998) have been demonstrated in preliminary studies to be valid tools for assessment of level of care requirements for individuals with addictive disorders and psychiatric disorders, respectively. Both instruments use a multidimensional assessment format to determine multiple dimensions of service intensity that comprise appropriate placement. ASAM PPC2R (2001) incorporates additional capacity for level of care assessment and placement for individuals with co-occurring disorders, though it has not yet been field tested.

- 8. Based upon all of the above together, there is no single correct dual diagnosis intervention, nor single correct program. For each individual, at any point in time, the correct intervention must be individualized, according to subgroup, diagnosis, stage of treatment or stage of change, phase of recovery, need for continuity, extent of disability, availability of external contingencies (e.g., legal), and level of care assessment.**

This paradigm for treatment matching forms the basis for the design of the practice guidelines.

- 9. Outcomes of treatment interventions are similarly individualized, based upon the above variables and the nature and purpose of the intervention. Outcome variables include not only abstinence, but also amount and frequency of use, reduction in psychiatric symptoms, stage of change, level of functioning, utilization of acute care services, and reduction of harm (Drake et al, 2001; Minkoff, 1998).**

## 6.5 APPENDIX E: (5 of 6)

### Principles of Practice for Family Psychoeducation Groups

*The multiple family group intervention will be most effective when:*

#### Start-up

- Group membership is determined by diagnostic category.
- Groups are as closed as possible to discourage drop-out and increase comfort / familiarity.
- Group membership is fully voluntary.
- 9-12 months is set as the target length of group with meetings. This does not need to be communicated to potential participants.
- Group is conducted every other week.
- Psychiatrists co-facilitate the groups, when possible.
- The culture of group members is represented by one of the facilitators.
- Use the clinic or location that consumers and families regularly use. Don't send members to another clinic for group.

#### Pre-joining

- Hospital Liaison, inpatient staff, and other referral sources understand and advocate for the use of multiple family group.
- Referral sources work collaboratively with outpatient staff to engage the consumer and family members in the pre-joining process.
- Pre-joining occurs when people are in crisis, or when the consumer has experienced their first episode (as early as possible in the onset of the illness).
- Consumers without identified family or friends are encouraged to include a "sponsor".

## 6.5 APPENDIX E: (6 of 6)

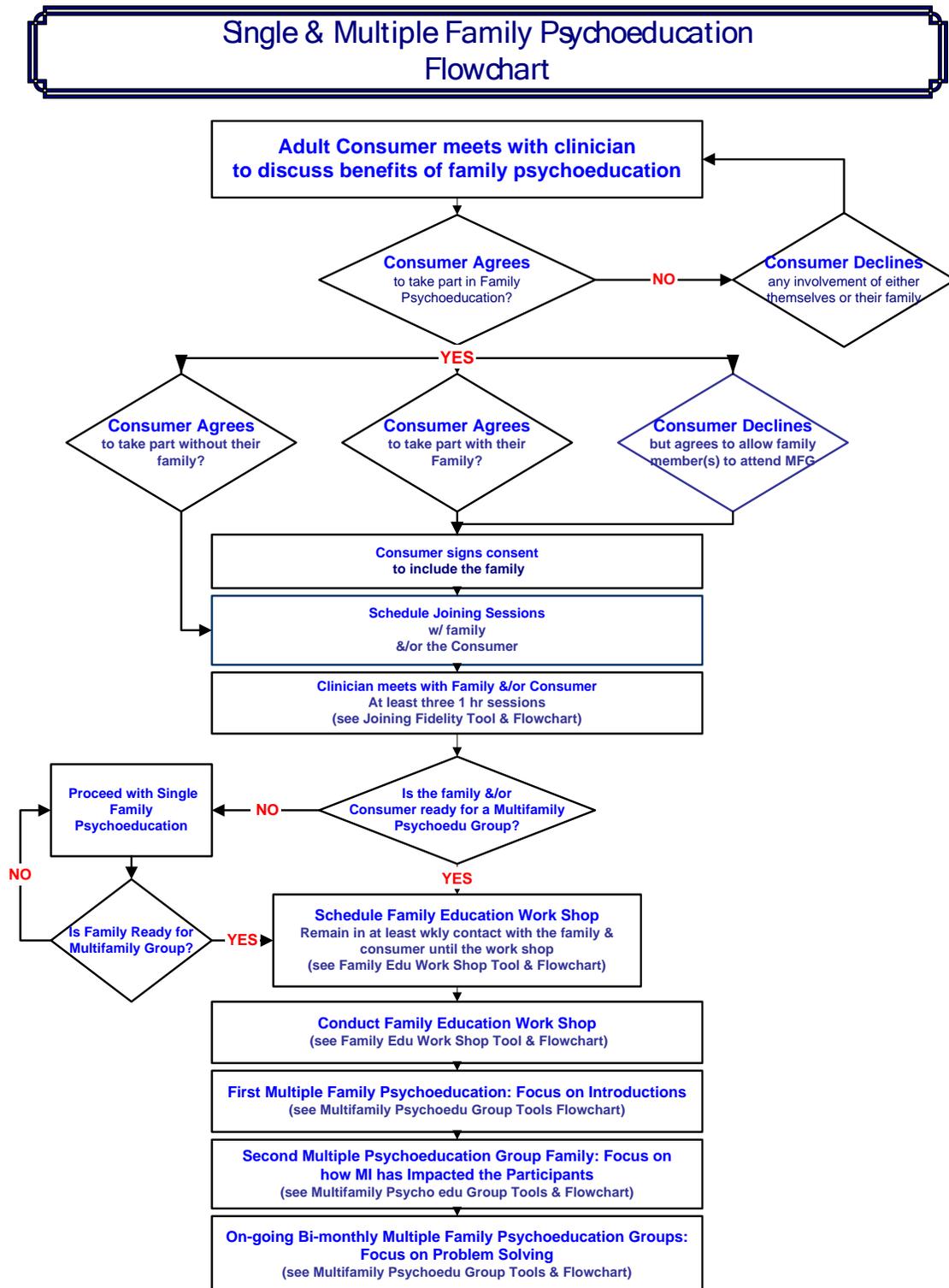
### Joining

- Facilitators start with existing relationships. Facilitators will be more successful in engaging consumers they are already working with.
- Facilitators use 3 to 5 sessions to join and understand what the consumer / family members want from group.
- Single family group is used until members are ready to join the multiple family group, OR as an alternative family intervention.
- New members are introduced to group in pairs.
- Group members are prepared to welcome and accept a new family to group.

### On-going sessions

- Members attend group. They can gain a lot just by listening.
- Quick advice is given during go-around and other more significant / serious issues are addressed after the group or through additional meetings outside of the group.
- A timekeeper is used to finish group (keep go-around short).
- Group structure is followed so that irritation of group members is kept to a minimum.
- Group members support adherence to medication.
- More consumer participation is incorporated into the structure – keep things moving forward.
- Facilitators decide on the focus problem. Avoid generic problems. Refrain from determining problem by consensus or majority.
- Group problem-solves current issues and goal attainment.

6.6 APPENDIX F:



## 6.7 APPENDIX G:

**SAMPLE CSTS Quarterly Project Work Plan****Project:** ATO Team **Quarter:** Jan 04 to 3-05 (7-05) **Date:** 1-15-05

	PROJECT AREA	TASK	LEADER	INVOLVED STAFF	MEASURE	OUTCOME	TIME LINE	DATE COMPLETE
1	ATO FMEA	Analyze ATO Failure Modes, produce new policy, procedure and staffing recommendations. [ATO Manual]	Policy Analyst	Health Services Supervisor, ACT,		New Procedures, policies and a specialized team to care for clients on ATOs. ATO Manual		Finished 12-04
2	ATO team proposal	Present ATO team plan to board, seek approval for funds to establish team.	Executive Director			Board Approved positions in 2-05		Finished 2-05
3	ATO Team--Space	Find Space for the ATO team (4 extra desks, computers etc.). Plan to move Residential Staff by May '05 to make room at Varsity site.	Department Director	Health Services Supervisor, ACT			5-05 Res. staff moved	Finished
4	ATO Program description	Write ATO Program Description including staff descriptions	Health Services Supervisor, ACT	ATO team staff		Program and staff descriptions	3-05	Finished
5	Hiring staff	Hire staff as space and referrals allow/dictate. Since there is only space for the current 2 staff, no additional hiring can be done until space is found. The other staff limitation is no additional MD time until 7-05. By 7-05 the team should have 2 CSMs, an RN and a Service Coordinator (if space is secured). After 7-05 further hiring will be determined by referral pace.	Health Services Supervisor, ACT	ATO team staff		Hire staff as space allows until 7-05. After 7-05 pace of hiring determined by referrals.		Finished

**WCHO Community Action Planning (SAMHSA-funded)**

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## 8.0 Additional Resources

### 8.1 Other Helpful Reference Works

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## **8.2 Helpful Databases and Search Engines**

Compendium of Research Related to Mental Health

<http://www.ahrq.gov/research/mentalcomp/#contents/>

National Guideline Clearinghouse

[http://www.guideline.gov/resources/guideline\\_index.aspx/](http://www.guideline.gov/resources/guideline_index.aspx/)

Center for Evidence-Based Practices

<http://www.evidencebasedpractices.org>.

Evidence-Based Medicine Resource Center

<http://www.ebmny.org/>

SAMHSA's National Mental Health Information Center

Evidence-Based Practices: Shaping Mental Health Services Toward Recovery

<http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp/>

## **8.3 Web Journals**

Evidence-based Online

<http://ebmh.bmjournals.com/>

Cochrane Library

<http://www.cochrane.org/reviews/clibintro.htm>

<http://www.cochrane.org/index0.htm/>

Turning Knowledge Into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices.

<http://www.tacinc.org/Pubs/TKIP.htm/>

## **8.4 Web Publications**

Evidence-Based Extension

<http://www.joe.org/joe/2004april/a2.shtml/>

Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century.

<http://www.nap.edu/books/030907208/html/>