

Integrated Treatment

CASE STUDY OF IMPLEMENTATION: BLUEGRASS REGIONAL MENTAL HEALTH AND MENTAL RETARDATION BOARD

Submitted to:

**The Department for Mental Health
and Mental Retardation Services'
Evidence-Based Practice Advisory Board**

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Client Protections

The plan to conduct case studies as part of the Evidence Based Practices II Bridging Science and Services project was reviewed by the Cabinet for Human Services' IRB Administrator and found to be exempt from review pursuant to 45 CFR 46.101(b)(5).

A Consumer Talks about her Experience with Integrated Treatment

A Team Approach:

In 2000, Diane spent over two thirds of the year in the hospital after repeated struggles with symptoms of Bipolar Disorder complicated by years of abusing alcohol and numerous drugs. She estimates that she was previously hospitalized eight times. In addition to the hospital and residential substance abuse programs, Diane has been engaged by many people and services within Bluegrass over the years, including but not limited to outpatient therapy, a therapeutic rehabilitation program, outpatient groups, a psychiatrist, and case management. Before the start of the integration effort she states that the people she worked with weren't always open to talking about the "substance abuse piece" or how it plays a role in my mental health problems...and looking back I don't think I was getting what I needed even though I was getting a lot of services." However, at the beginning of the Bluegrass integration effort her "team" met, planned together, conferenced with the hospital, and acted consistently to simultaneously help address her mental illness and substance abuse needs. As a result, from 2001 until this past year Diane enjoyed a remarkable period of stability: no hospitalizations, no drug or alcohol abuse, steady housing, some employment, participation in school, and developed a wider social network. When talking about a particularly stressful period, after the death of her husband in 2002, she states, "I don't know what I would have done or how far I would have dropped if I didn't have the supports at Bluegrass helping to keep me from relapsing with my substance abuse and mental illness. I made it through my husband's death because of their help."

Although she experienced a significant relapse of her symptoms of bipolar disorder and limited substance abuse in 2006, resulting in three brief hospitalizations, she is now more stable again. She states that "the most important thing I have learned over the years is how my mental illness and substance abuse are so close together." When asked how her life would be different if the supports she receives didn't address both areas of concern, she replies, "I would have been dead or in jail when things got bad again this year...and instead I made it through OK, I still have a place to live, continued with my services here, kept my relationships, and I'm back to not using any alcohol or drugs." When asked how the people involved in her care help her, she states, "a door is always open here to get help with either thing I need the most help with at that time...and that's different than it used to be... the supports I have at Bluegrass help me catch the early signs that I'm having trouble and they bend over backwards to make sure I get what I need...they have helped bring out the best in me and helped me believe in and care about myself."

Section
1

Introduction

Purpose of the Case Study

This organizational case study is part of a one-year project funded through a joint SAMHSA/NIMH grant to the Kentucky Department of Mental Health and Mental Retardation Services. The overarching goals of the project are to enhance Kentucky's knowledge base for implementing evidence-based practices and to utilize this knowledge to promote implementation of evidence-based treatment practices in Kentucky's public mental health system. In addition to this and one other case study, funds from this grant have been utilized to support the formation, education and training of an Evidence-Based Practice (EBP) Planning Group, as well as identification of university-based linking agents to foster the development of science-to-service collaboratives.

The purpose of this case study is to assist the EBP Planning Group gain an in-depth understanding of the process of implementing an evidence-based practice within a community mental health care organization. Case study data are presented within six developmental stages of EBP implementation described by Fixsen, Naoom, Blase, Friedman, & Wallace (2005). These stages include: *Exploration and Adoption, Program Installation, Initial Implementation, Full Operation, Innovation, and Sustainability*. Within these areas, several themes are emphasized throughout the discussion: (1) factors that facilitate or impede successful implementation, (2) effective dissemination techniques, (3) cultural or community adaptations, and, (4) indicators of organizational readiness to undertake the adoption of an evidence-based practice.

The information presented in this case study was gleaned from a review of documents and extensive interviews of a representative sample of administrators, clinical supervisors and staff, and consumers.¹

¹ A more detailed description of the case study methodology may be obtained from REACH of Louisville, Inc.

Context

Use of evidence-based integrated treatment services for individuals with co-occurring mental illness and substance abuse disorders by the Bluegrass Regional Mental Health and Mental Retardation Board (Bluegrass) is the focus of the present case study. Bluegrass is one of the largest community mental health organizations in the country and serves over 25,000 people annually within the seventeen counties of Central Kentucky.

The evidence-based initiative, often referred to in the literature as Integrated Dual Diagnosis Treatment (IDDT), began in 2001. Within this approach, clinicians are taught to provide mental health and substance abuse interventions in an integrated and coordinated fashion. Although IDDT is not limited to a finite set of manualized therapeutic practices, it does create the expectation that clinicians will utilize information and evidence-based practices related to the treatment of both disorders. These include practices related to the use of motivational interviewing techniques, assessing for the presence of and severity of a client's substance abuse, assessing level of care required, and using stress management, coping skill, and relapse prevention strategies.

At an organizational level, IDDT involves developing an integrated philosophy of treatment, altering organizational structures to promote integration of assessment and treatment services, and increasing communication and collaboration throughout the continuum of services. Although a SAMHSA toolkit now exists to aid organizations with this EBP, none existed at the time this initiative began. Prior work by Kenneth Minkoff, a leading authority within the field of integrated addiction and psychiatric services, was used as a guide for the Bluegrass project.

Current status

At present, the major activities of the original implementation plan have been completed. The intended goals for the initiative are best captured in the mission statement for the initiative. They focus on access, responsiveness, and integration. Core elements of the change effort included leadership and infrastructure support, systematic training of staff, availability of consultation, provision of written materials, revisions to policies and procedures, development of a fuller service array, and internal evaluation. A mission statement related to serving people with co-occurring disorders in an integrated manner was developed and communicated to staff throughout the agency. Revised substance abuse assessment procedures are in routine use and the two training modules developed during the initiative are now conducted biannually for new clinical staff. Project leadership report that they have created and begun to deliver a new training session for substance abuse staff regarding the identification and treatment of major psychiatric disorders.



Bluegrass Regional Mental Health and Retardation Board Stages of Organizational Change in the Implementation of Integrated Treatment

Exploration and Adoption Stage

The purposes of exploration are to: (1) assess the potential match between community needs, evidenced-based practices, program needs, and community resources; and, (2) decide whether or not to proceed with implementation. Both formal and informal criteria may be used to make this decision. Common pre-implementation activities include stakeholder information exchange, assessing the fit between a potential approach and community needs, and mobilizing information and support. Successful negotiation of this stage can result in a clear implementation plan (with tasks and time lines) to facilitate the installation and initial implementation of the program. The support of political, financial, and human service systems at state and local levels is garnered during the adoption process and remains important throughout all implementation stages (Fixsen et al., 2005).

Identification of need

In Bluegrass, a seminal event in the move toward integrated treatment was a 2001 quality improvement project involving intensive case reviews of “high users” of psychiatric hospital services.² This effort revealed that a high percentage (approximately 70%) of clients with multiple admissions to the hospital had concurrent substance abuse and mental health disorders. The data garnered from this project solidified the awareness of organizational leaders of the need to improve treatment of clients with co-occurring psychiatric and substance abuse concerns. It also highlighted the cost of not addressing

² Since 1995, Eastern State Hospital has been managed by Bluegrass Regional Mental Health and Mental Retardation Board under a contract with the Cabinet for Health and Family Services’ Department for Mental Health and Mental Retardation Services.

this issue. As a result, a specific task force was created to examine how best to address the issue of providing more effective treatment for these consumers.

Several key leaders in the organization had a preexisting interest in this area, and some early events laid the groundwork for the present effort. For example, as early as 1993 two staff members attended a workshop by Minkoff that encouraged cross-training and consultation between mental health and substance abuse staff. However, this did not result in an organization-wide effort with central office support; and the energy associated with these ideas dissipated. In 2000, the director of substance abuse programs began to develop training for mental health staff regarding substance abuse assessment and treatment. Both of these efforts provided useful lessons; and, the resources and knowledge of these and other key staff members became a significant resource for the later, more formalized effort.

Similarly, there was a long history of the importance of integrating substance abuse and psychiatric treatment among the staff at Eastern State Hospital (ESH). In 1988, the hospital began developing (and eventually implemented) a Drug/Alcohol Education program.

Finally, it had become apparent to state-level officials that individuals with co-occurring disorders were having difficulty in transitioning from psychiatric hospitals into outpatient programs that could address both their mental illness and their substance abuse disorders. In some instances, service eligibility criterion had been set that eliminated these individuals from critical services. To address this, the DMHMRS issued a policy statement to the community mental health centers mandating that chemically dependent patients discharged from the state psychiatric hospitals receive appropriate community-based outpatient, residential treatment, and/or aftercare support on a timely basis. This mandate became effective in 1990 and resulted in a need for closer collaboration between the psychiatric hospitals and residential substance abuse programs.

Decision to act

The decision to act was made by the Vice President of Clinical Services (VPCS) based on a combination of factors: (1) a genuine concern for improving care for consumers, (2) a desire to reduce unnecessary costs caused by “high users”, (3) dissatisfaction with the current state of treatment for this specific group of consumers, and (4) confidence that there were sufficient sources of expertise and support within the organization. These considerations were coupled with relatively high confidence in the organization’s ability to manage the risk of implementing such an initiative, particularly the risk associated with the cost of planning and implementing new policies and practices. From a risk-benefit perspective, individuals involved in the initiative expressed the belief that there was great potential for significant, worthwhile improvements in the delivery of integrated treatment services.

A high degree of administrative commitment during initial stages was consistently reported. For example, the Vice President of Clinical Services created a Dual Diagnosis

Task Force and incorporated progress reports into monthly Service Area Manager meetings. This had the effect of keeping the subject in the foreground. However, a period of financial pressures during the implementation period caused some interruptions in the planning and development process.

Leadership structure and communication patterns

Leadership was provided through the Dual Diagnosis Task Force, comprised of individuals with specific interest in this area. Participants typically had long, positive, preexisting relationships with each other. There were consistent reports that this group was unified and efficient in its work and that decisions were typically made through consensus-building. The task force developed a mission statement, conducted a literature review, visited other programs, and attended national trainings. Ultimately, the group oversaw the development of staff training, new assessment approaches, policy changes, and systems for planning and monitoring. A Service Area Manager and the Director of Substance Abuse Services played key roles as staff support, as did the VPCS.

Communication was facilitated through the monthly Service Area Manager (SAM) meeting, with the key project leaders as consistent participants. This forum provided opportunities for both “horizontal” (across primary organizational leaders) and “vertical” (up and down the chain of command) communication. Specifically, SAMs had monthly “Hub” meetings with all Clinical Coordinators (managers of several programs within a given county) and individual program directors/supervisors within the counties they supervised. Individual program directors/supervisors typically had weekly meetings with frontline staff.

Another mechanism for communication was the Professional Staff Organization (PSO). This committee was comprised of key administrative leadership and local representatives from each “Hub” and supplied a venue for exchanging feedback between the frontline staff and upper level management. These same leaders attended these sessions routinely. The name of the PSO committee was later changed to Clinical Leadership Committee, and it recently has undertaken more specific tasks related to examining potential additional evidence-based practices to be implemented within the organization.

Organizational and staff readiness

There was no formal pre-implementation assessment of organizational or staff level readiness. However, informal assessments of factors related to organizational readiness were undertaken by task force members through discussions with key staff. They considered such factors as the resources available for implementation, appropriate means of accomplishing training, and policy and procedure changes. Informal assessments by project leaders focused on gauging the level of staff receptiveness to the goals of the initiative and the degree of experience among various program teams and individuals in addressing substance abuse issues.

More formalized assessments of organizational and staff readiness took place after many of the components of the initiative (such as Level 1 training), had begun. These included: (1) a front-line staff survey, (2) consumer interviews, (3) an organizational “GAP” assessment, and (4) a self-assessment at the initiation of Level I training. The survey of front-line staff covered topics related to what information and materials in the initial training the staff found most helpful. The survey also attempted to assess staff perceptions of the areas in which they needed to increase their proficiency. The survey revealed that over 60% of staff (n = 68) desired more training and materials, while almost 50% wanted more treatment options and greater access to supervision/consultation.

Additionally, five individual consumer interviews were conducted by one of the task force members. The interviews were conducted with clients who had experienced substance abuse and mental health difficulties and showed some improvement. Interview questions related to which components of the assessment and treatment process at Bluegrass were particularly helpful, which were not as helpful, and ideas to improve the services for clients with co-occurring disorders. Elements identified as particularly helpful included the structure provided within programs such as therapeutic rehabilitation programs (i.e. dependable, busy schedule, less contact with negative peers), treatment activities that increased positive peer supports, learning Dialectical Behavior Therapy (DBT) and other practical self-management skills, regular medication management, help with obtaining housing outside of their previous neighborhood, and support from and open access to a case manager and individual therapist. Ideas to improve services included earlier integration of substance abuse and mental health treatment and increased peer support and intervention, particularly in the early stages of treatment.

The Hub gap assessment involved collecting information from each Service Area Manager and Program Director (for all components of the agency, including outpatient programs, case managers, substance abuse residential programs etc.) regarding the current status and capacities within each county and program. The overall strengths identified by the assessment revealed that most staff were “on board” philosophically with the goals of the initiative, most offices had staff who were trained in both mental health and substance abuse, many counties already were utilizing a team approach to working with individuals with co-occurring disorders, and the number of intensive outpatient programs and substance abuse treatment groups had increased. Primary areas of need included desire for additional clinical resource materials for clients of different age groups, Level I and II trainings to be offered multiple times a year, identification of staff for consultation with certain programs and/or counties, and development of a dual diagnosis outpatient track in certain counties.

Finally, staff attitudes and beliefs regarding substance abuse and the goals of the initiative were assessed at the beginning of the Level I training. Following a review of the mission and goals, the training included a self-assessment entitled, “What are my feelings and beliefs about substance abuse?” This was used to provide an opportunity to openly address various staff beliefs and attitudes regarding substance abuse and substance abusers. It provided a foundation for addressing common misperceptions regarding substance abuse that, if left unaddressed, might lead to less “buy-in” from the staff.

Although the organizational climate was not formally assessed during the planning stages of the initiative, data gleaned from case study interviews suggest that most staff perceive a positive organizational climate for change, high level of trust with substantial autonomy and flexibility, and willingness to learn, all of which are related to organizational readiness.

Selection, training and staff support

Substance abuse training for mental health professionals was a central component of the initiative. When an appropriate, preexisting curriculum could not be identified, the task force chose to create local content tailored to the needs of their agency. Ad hoc committees were assigned with the task of creating the Level I and Level II basic substance abuse training content. The first was intended for all staff, and the second was intended for all direct clinical and supervisory staff. Level I “Basic Substance Abuse Counseling” training focused on introducing the initiative, addressing the differing views of the causes and models of treatment of substance abuse, and reviewing components of substance abuse assessment and counseling strategies. The Level II training contained more detailed information regarding the topics of engagement and motivation, adolescent treatment, co-occurring disorders, and provided more counselor resources such as treatment planning guidelines and worksheets for clients to utilize in therapy.

Training was disseminated through a training of trainers approach. Task force leaders trained two trainers from each HUB, who in turn were responsible for training staff in their area. During the initial training of trainers sessions, project leaders focused on both content and process. The training committees included a variety of effective delivery strategies to maximize learning, with varied instructional strategies such as lecture, handouts, videotapes, group discussion, case example exercises, and role playing. In an effort to foster consistency among the trainers, training outlines were created, with instructions for the sequence and methods of presenting information and supplemental materials. A question related to the quality of the presenter was included on the pre-post training survey, which provided the task force leaders with some general feedback as to the perceived quality of the presentations. However, no practice opportunities or monitoring mechanism for observing and evaluating inter-trainer consistency were implemented.

Staff were initially informed about the initiative through dissemination of a document describing the need and accompanied by a mission statement.³ It stressed the need for better linkage between mental health and substance abuse and the relationship of the initiative to the overall goals of the agency. The aforementioned self-assessments and GAP assessment helped identify staff members perceived as less open to the initiative, and these data were used to address specific concerns, misconceptions, and resistance. Ongoing follow-up related to material covered in the training occurred through individual and group case consultation with more experienced staff.

³ Relevant portions of the Task Force Mission Statement can be found in Appendix A

Program Installation

Program installation involves generating structural supports necessary to initiate the program. These include ensuring the availability of funding streams, employing appropriate human resource strategies, making appropriate revisions to policy and program manuals, and developing frameworks for accountability and outcomes. Additional resources may be required to realign current staff, hire new staff members to meet the qualifications required by the program or practice, secure appropriate space, purchase needed technology, fund unreimbursed time in meetings with stakeholders, and fund time for staff while they are in training (Fixsen et al., 2005).

Funding, cost, and resource utilization

Planning and implementation activities were funded solely within the existing organizational budget. No new personnel were hired and no new positions were created with dedicated responsibilities related to the project. Instead, the workload was added to existing employees' responsibilities, many of whom volunteered to participate. The majority of the individuals who participated in the planning efforts were salaried administrative or supervisory level staff who do not bill for direct client contact in any case. Their primary responsibilities included attending task force and other meetings, making site visits, attending conferences, conducting research, designing the training content and implementation plan, organizing and conducting the training of trainers, and engaging in internal evaluation activities.

Additional costs to the agency came in the form of lost billable hours. The training of trainers sessions and the subsequent staff trainings each cost the organization approximately one day of billable time per participating staff member, for example. Similarly, consultation services provided by the agency's most expert clinicians represented time that could otherwise have been available to direct services. The most significant cost to the agency, however, was felt in the delivery of additional substance abuse services without an expansion in the substance abuse funding streams. Integrated treatment presumes that the individual's substance abuse, in addition to their mental illness, will be treated. However, federal and state funding streams for substance abuse are fixed and limited.

The lack of external funding and the limited reimbursement potential for substance abuse services were overarching concerns related to achieving the goals of the initiative. The absence of new dollars for program development or service delivery affected the amount of expert consultation available to project planners, the ability of the agency to increase the service array options, the amount and format of training and consultation for staff, and the number and thoroughness of implementation and outcome monitoring efforts.

Alignment of policies/practices and organizational structures

Although the organizational structure of the agency was not altered as a result of the decision to pursue a model of integrated treatment, a number of changes were made to the policies and practices of the organization. Examples of these changes are listed below:

- ✓ Information related to the mission and goals of the initiative was added to the new employee orientation.
- ✓ Completion of the Level I and II basic substance abuse trainings became required in-service trainings for applicable existing staff and newly hired staff.
- ✓ New substance abuse questions and screening instruments were added to the client intake process.
- ✓ Treatment planning guidelines for substance abuse/dual diagnosis concerns were created.
- ✓ Changes were made to the quality assurance procedures to monitor for consistent completion of the screening instruments and for treatment plans that include integrated treatment when both mental illness and substance abuse concerns were identified.
- ✓ Elements were added to clinical staff performance evaluations to address their degree of proficiency with substance abuse assessment and treatment, based largely on case reviews by direct supervisors.
- ✓ Admission and discharge criteria for certain programs were redefined.
- ✓ An “Enhanced Dual Diagnosis Addiction Education Program” was briefly implemented at Eastern State Hospital. Preparations for this program involved numerous policy and practice modifications, including drafting admission and discharge criteria; organizing the program components; drafting program description and treatment materials; delivering additional staff training; developing practices regarding discharge planning and linkages to residential, outpatient, and case management programs; defining length of stay expectations; and identifying related funding processes

Two examples of less formal procedural changes include accepting dual diagnosis clients into existing intensive outpatient programs and Eastern State Hospital clients into the Schwartz Center (a residential substance abuse treatment center located on the same property as the hospital).

Initial Implementation & Full Operation

Initial implementation is marked by the point at which staff are in place, referrals begin to flow, organizational supports and functions begin to operate, external agents begin to honor their agreements, and individuals begin to receive services. Change does not occur simultaneously or evenly in all parts of a practice or an organization. Changes in skill levels, organizational capacity, and organizational culture, require education, practice, and time to mature. During the initial stage of implementation the compelling forces of fear of change, inertia, and investment in the status quo combine with the inherently difficult and complex work of implementing something new. And, all of this occurs at a time when the program is struggling to begin and when confidence in the decision to adopt the program is being tested. Full operation is achieved as the staff become skillful and the procedures and processes become routinized. System integration, information feedback loops, and attention to solving ongoing management, funding, and operational issues are notable features of advanced implementation (Fixsen et al., 2005).

Although there was no formal, comprehensive assessment of the degree of successful implementation, several monitoring mechanisms and the case study activities yielded information about the degree of standardization of many of the planned components.

- ✓ Level I (all staff) and Level II (all clinical and supervisory staff) were completed as planned. Both are now conducted biannually to meet needs of new personnel. These trainings were designed for clinicians in the mental health program who needed knowledge and skills in the treatment of substance abuse if they were to successfully address the needs of their clients. Additional trainings for other target groups (ex. case managers, crisis unit staff, and psychiatrists) with adapted content were conducted as planned but are not ongoing. There have been no follow-up sessions since the original implementation phase. More recently, a third training committee was formed to create a curriculum designed for clinicians in the substance abuse field who need knowledge and skills in the treatment of mental illness. Delivery of this training began in the Fall of 2006.
- ✓ Internal survey data indicates that Level I training participants consistently demonstrated a relatively high degree of success in learning the information presented, as measured immediately after the completion of the sessions. The

average score on Level I pre-test was 50%, and the average score on the post-test was 74%.⁴ However, case study data suggests wide variability in use of the information in clinical practice, other than the mandatory assessment components. The most frequently utilized components of the training appear to be: motivational interviewing, assessment information used to determine the appropriate level of care, expected withdrawal symptoms, and the level of detoxification supports required for a given client.

- ✓ Supplemental materials on substance abuse and co-occurring disorders were purchased and provided to all intended programs.
- ✓ During the initial phases of implementation, the in-house consultation mechanisms appeared to be utilized and successful. However, external pressures on limited clinical/consultation resources, coupled with the lack of dedicated project funding, made it difficult to sustain the level of individual and group consultation focused on this population.
- ✓ More informal consultation and information sharing is occurring through an increase in the level of communication and collaboration within specific outpatient offices and their associated programs and personnel. Less increase was noted in counties that have programs that are not co-located (more urban settings) and between outpatient offices and inpatient/residential programs. (Variables impacting the degree of increase in communication and collaboration are outlined in the description of factors impacting implementation success.)
- ✓ New assessment questions and instruments were integrated into the intake process and made mandatory. Monitoring mechanisms suggest they are being conducted consistently across programs
- ✓ In spite of the relative lack of project funding as well as the lack of external resources to support substance abuse/integrated treatment in outpatient settings, there were a number of services added within the agency to address the needs of clients with co-occurring disorders. These included: (1) opening several intensive outpatient programs (IOPs) to serve clients with co-occurring disorders, (2) creation of several substance abuse/dual diagnosis groups, (3) expansion of outpatient substance abuse groups, and (4) addition of an adolescent group related to mental health and substance abuse issues. Although there are no specific data available, the general consensus of case study participants is that there has been an increase in the utilization of individual therapy resources to address issues of substance abuse and co-occurring disorders.
- ✓ Finally, Eastern State Hospital's Dual Diagnosis track was successfully created and implemented with a small set of clients. However, soon after implementation, external pressures related to a substantial increase in demand for hospital admissions, coupled with more difficulty securing funding for the planned extended stays of clients, caused elimination of the program.

Anecdotally, clinical coordinators and front-line clinicians consistently reported that they perceived an improvement in the awareness of substance abuse as a potential problem to be addressed. They also perceive that clients are now afforded access to a somewhat wider array of treatment services within most of the outpatient settings.

⁴ An analysis of the Level II trainings was not available for review during the case study activities.

Some intermediate variables, such as the number of clients being identified, can be tracked through existing internal data systems. However, mining and exploring these data was outside the scope of this project. While no specific client outcomes were tracked in terms of symptom reduction, functioning or quality of life, interviews with consumers revealed positive responses to treatment that addressed both their substance abuse and mental illness. They associated integrated treatment with improvements in symptom reduction, functioning, coping skills and stress management, and their ability to manage crises and prevent or minimize substance abuse relapses.

Innovation & Sustainability

Each attempted implementation of evidence-based practices and programs presents an opportunity to learn more about the program itself and the conditions under which it can be used with fidelity and good effect. Staff members working under different conditions within uniquely configured community circumstances present implementation challenges. They also present opportunities to refine and expand both the treatment practices and programs and the implementation practices and programs. Some of the changes at an implementation site will be undesirable and will be defined as program drift and a threat to fidelity. Others will be desirable changes and will be defined as innovations that need to be included in the “standard model” of treatment or implementation practices. At this point, a new program is no longer “new.” As the implementation site settles into standard practice, internal and external factors impinge on a program and lead to its demise or continuation. Coping and adaptation are notable features of sustainability with respect to continuous training for practitioners and other key staff (as staff turn over), changes in priorities and funding streams within local systems, changes in leadership, and changes in community or client composition. (Fixsen et al., 2005).

Extent of innovation

While Minkoff’s model of integrated treatment contained many of the components that the task force found desirable; there was no intent on the part of Bluegrass staff to implement the model with strict fidelity. Therefore, variations in the initial implementation and changes over time are not construed to be improvements on the original model. Rather, they were practical adaptations to the real world setting of a large and complex service delivery system.

A strength of the effort was that task force members and administrative leadership were willing to receive and respond to feedback, while attempting to adhere as closely as possible to implementation and treatment model practices that were being promulgated. This was particularly evident in the modifications made to training as a result of participant responses to the pre- and post-training surveys. Not only were changes made to Level I training, but the Level II curriculum was developed in direct response to feedback from clinical staff that they wanted more in-depth information on the assessment and treatment of clients with co-occurring disorders.

Sustainability

Staff at all levels reported that Bluegrass administrators and key clinical leadership were committed to sustaining the gains that have been made as a result of this initiative. Certain elements, such as the new intake assessment practices, can be sustained without the infusion of new resources. Other elements, such as the Level I and II trainings, will require the ongoing commitment of staff time and direct costs associated with delivering the training and reproducing the training manuals. There is consensus that these two elements will be maintained indefinitely.

Other core aspects of the initiative, such as the creation of clinical consultation mechanisms and the creation of additional outpatient services for individuals with co-occurring disorders, are more difficult to sustain within the current funding environment. It was the consensus of many of the informants that funding levels will continue to decline unless there is a change in Medicaid reimbursement policies or an increase in federal, state, or third-party funding for substance abuse services. Similarly, the fiscal challenges that caused the elimination of the ESH Dual Diagnosis track remain, and there are no plans to reopen those services in the foreseeable future.

In sum, there appears to be continued commitment to the goals of the initiative but a practical acceptance of the limitations which constrain full implementation and influence sustainability.

Multi-Systemic Facilitators and Inhibitors

It has been suggested that there are five intersecting systems within which variables can impact the implementation of an innovation (Panzano, Seffrin, Chaney-Jones et. al., *in press*). These include the environmental level (system and professional norms), inter-organizational level (communication between adopting organizations), the adopting organization (degree to which the organization sees itself as a learning organization and is willing to take risks), project level (resources for project management and support); and innovation level, (scientific evidence and complexity). This paradigm provides a framework for organizing case study observations.

Environmental Level

Professional:

- The historical separation of training, certification/licensing, and practice domains for professionals within the mental health and substance abuse fields continues to be a significant impediment to the integration of these services for clients within “real life” treatment settings, such as the community mental health centers.
- High turnover of clinicians within the CMHC system and limited access to a sufficient number of qualified clinicians (particularly in rural areas) creates challenges for maintaining the “organizational learning” generated by this and other similar projects. The competing demands on senior clinicians and supervisors also are barriers to retaining adequate numbers of trainers and ensuring adequate transfer of learning into practice of newly trained staff.
- Many of the clinicians within the Bluegrass outpatient settings are licensed to practice autonomously. Therefore there is often no preexisting allocation of time for supervision (other than informal peer consultations, staff case planning and treatment team meetings) within which to insert supervision/consultation regarding a new practice.

System:

- The lack of adequate reimbursement streams for the provision of substance abuse services presented a significant barrier to the integration project. Medicaid does not reimburse for substance abuse treatment services (other than for pregnant

women or postpartum mothers and youth with extraordinary treatment needs). The amount of monies provided to the CMHCs by the DMHMRS for substance abuse services is insufficient. Finally, the managed care service approval system consumes resources of the clients and clinicians and often requires the abrupt discontinuation of services or a decision to continue services without payment (other than a “line fee” from the client).

- Overall financial pressure on CMHCs often result in the discontinuation of services that operate at a loss (like many of the intensive outpatient programs). On an individual program level, financial strain forces supervisors to ensure that clinicians are maximizing their potential billable hours. This often requires limiting non-billable activities that are key to the successful implementation and sustainability of evidence-based practices, such as, consulting activities, peer supervision, and training.
- High client volume in many CMHC offices also results in less time being available for clinicians and other staff to participate in activities related to the implementation of a new practice.
- Factors related to clients’ resources, particularly in the area of transportation, also were found to impede the degree to which the clients could participate fully in the array of integrated services.
- The overall lack of availability of higher level substance abuse services, such as intensive outpatient and residential services, created a significant barrier to the planful, integrated provision of these services.

Inter-Organizational Level

- In many counties, clients in need of residential substance abuse services or hospitalization were referred, out of necessity, to programs outside the organization. This often created additional barriers to the continuity of services, before, during and after their placement in these programs.

Organization Level

- Bluegrass’ sheer size (serving 17 counties, 25,000 clients a year) and organizational complexity presented a significant challenge across all stages of the implementation process.
- There was a consistently expressed view that Bluegrass has a positive organizational climate, particularly at the administrative and supervisory levels, in terms of openness to change and the willingness to attempt to identify needs and implement new practices to address them. There was also a re-occurring expression that the upper level administration and project leadership maintained consistent commitment to the current project, which appeared to contribute to the successes achieved.
- The relatively small group of project leaders at the administrative level had longstanding positive relationships with one another, experience with integrated treatment models, and extensive experience and understanding of the Bluegrass organization. Clear lines of authority were created from the outset of the project

and a significant degree of flexible authority was afforded to the primary task force group. Also, the decision-making and communication mechanisms utilized to support the planning and implementation of the project operated effectively and efficiently. All of these factors appear to have been significantly associated with the successes achieved during the project.

- Bluegrass maintained a relatively stable core of leadership at the program director and clinical coordinator level of the organization and “above” during the planning and implementation of this project. This lack of significant turnover appeared to benefit the degree of implementation success achieved. For example, there was relatively little turnover within the original trainers’ group. Even some of the key project members have stayed on part-time after their recent retirements.
- The Bluegrass leadership espouse a belief in evidence based practices and a desire to incorporate more of these practices into the environment of their organization. They continue to develop and implement other evidence-based practices and have created new organizational structures to facilitate these efforts.
- The continued development of an electronic medical record will facilitate communication and more unified treatment planning across treatment programs within the organization. The lack of this capability during the course of the project appeared to have had the most negative impact on collaboration and communication regarding consumers who required temporary placement within residential substance abuse treatment programs or were hospitalized. This was true even if they were placed within a treatment setting operated by the agency.

Project-Level

- The lack of supplemental grant funding and finite resources available within the existing budget limited the degree to which many of the activities were able to be implemented. This was repeatedly expressed by interviewees as they described the discrepancy between their views of ideal planning, implementation, and support activities and the realistic limits of their expectations for the project.
- Limited assessment and addressing of the individual readiness factors among supervisory staff and frontline clinicians during the planning and implementation stages appeared to have impacted the degree of buy-in and commitment to the project’s goals. Counties/programs in which the program director and/or clinical coordinator had previous experience with and personally supported the importance of integration efforts appeared to achieve higher degrees of implementation/routinization of the project activities. This limited the ability of the leadership to identify and address potential implementation barriers after the primary activities were initiated.
- While some formalized monitoring activities occurred, for example the monitoring of training attendance, there was relatively little detailed feedback regarding degree of implementation of other key project activities. For example, there was little to no information gathered related to client outcomes associated with project goals. This limited the potential of project leadership to increase support for the initiative and motivate staff to sustain their efforts to implement the project activities.

- Changes to the client quality assurance/service review and staff performance review mechanisms were well-aligned to insure the basic activities were being conducted; however, this data was not specifically utilized by the leadership group to monitor implementation or as evidence of positive outcomes.
- While the ESH dual diagnosis track was successfully created and implemented with a small set of clients, its elimination during the early implementation phase significantly hindered the integration of treatment for those individuals who required hospitalization during the course of their treatment.
- Due to the limited resources of the project, there was no consultation with purveyors of integrated treatment models/practices, such as Minkoff, after the planning phase of the project. This limited their ability to learn from others' experience in implementing the practices and organizational change elements of the integrated treatment approach.
- The intended support/consultation activities for clinicians focused on transferring their learning into actual practice. The degree to which time was devoted to this form of support varied across outpatient offices. The differences depended on several factors, including the degree of buy-in of the program director and clinical coordinator, the client volume of the office, the number and interest of the clinicians with substance abuse treatment experience, and the preexisting consultation practices within the given office. Even in offices that developed numerous consultation opportunities for the clinicians related to this project, pressure to generate billable hours made it difficult to find sufficient time for consultation and training.
- The task force and ad hoc committees functioned well and created extremely well-organized and high-quality training manuals. They also consciously discussed and included a variety of training approaches in an attempt to increase the likelihood that information and skills would be transferred into practice.
- Activities to train the core trainers were extremely well organized and planned. These included reviewing both the content and process of the trainings (listing the sequence and type of activities to utilize in a written "how to" outline for the trainers). However, there was little follow-up to ensure that the trainers delivered the curriculum as planned.

Innovation Level

- The Substance Abuse and Mental Health Services Administration has endorsed IDDT as one of six-evidence based resource tool-kits funded by the federal government.
- The changes in clinical practice as well as organizational functioning required to fully implement IDDT models are more complex than the majority of evidence-based practices/programs. Therefore, substantial resources are needed during all stages of organizational change if the practice is to be sustained.
- Several Bluegrass personnel, within both the mental health and substance abuse programs, had previous exposure to, and interest in, the integrated treatment literature. Their experience with at least some strategies associated with IDDT was a helpful resource to the overall initiative.

- The research support, including specific client outcome data, for the effectiveness of integrated treatment approaches is increasing rapidly, as are the number of expert purveyors of specific models of integration.
- The Minkoff article served as an invaluable guide to the process of organizational change in addition to delineating the core elements in the integration of mental health and substance abuse services.

Successes, Challenges and Lessons Learned

There were numerous strengths of the Bluegrass initiative, both in terms of evidence-based practice outcomes and support given to the project. There were many challenges as well, and these were associated primarily with the complexity of the practice and the difficulty in bringing about change in a large organization. The general consensus was that, relative to the resources available for the planning and implementation of the effort, many significant successes were achieved.

Successes

In general, there was much congruence between administrative and clinical staff regarding the elements of positive change generated by the initiative. They listed the following among their successes:

- ✓ There is greater consistency in assessing for substance abuse concerns at intake and on an ongoing basis by mental health clinicians.
- ✓ Increased discussion and consultation is occurring between treatment team members within a given program regarding the substance abuse concerns of their clients and how these impact their treatment needs.
- ✓ A significantly increased number of Bluegrass mental health clinicians now feel comfortable addressing the mild to moderate substance abuse concerns of their clients. They also are more aware of when and how to refer clients with more severe substance abuse needs to a more experienced clinician and/or higher level of care.
- ✓ There are more clinicians with enough expertise and experience to provide consultation to other clinicians. For example, several clinicians gained valuable experience co-leading groups, specifically for individuals with co-occurring disorders, with the more experienced staff members.
- ✓ There has been a decrease in clinicians referring all clients with substance abuse issues to the identified team expert (the certified alcohol drug counselor), even in teams with several staff experienced in the treatment of substance abuse/co-occurring concerns.
- ✓ There is more awareness and access to psycho-educational materials to use with clients with substance abuse concerns as well as therapist resource materials related to assessment, treatment planning, and treatment activities.

- ✓ There is increased collaboration between programs within the same county that serve a given individual with co-occurring concerns, for example, between the individual therapist, the therapeutic rehabilitation (TRP) staff, case managers, and group leaders.
- ✓ Although many additional services stopped, several treatment services/programs initiated as part of this project continue to operate.
- ✓ New communication and collaboration relationships between the outpatient offices and other Bluegrass programs (Eastern State Hospital, residential substance abuse programs etc.) were created and many preexisting relationships were strengthened.

There also were some unintended positive outcomes of the project identified in the interview process.

- ✓ The training materials developed during the project are now being used to train crisis stabilization staff across the state in substance abuse assessment and basic intervention skills.
- ✓ The initiative served as a learning ground for project leadership, who gained valuable experience in planning and implementing an organization-wide, evidence-based practice. Bluegrass clearly has a number of experienced leaders who are capable of leading similar efforts in the future.

Challenges and Lessons Learned

- ✓ The amount of available resources dedicated to the implementation of a given evidence-based practice and related factors (e.g. the complexity of the program/practice being implemented and the size and complexity of the organization in which it is being implemented) set practical limits on the potential degree of successful implementation.
- ✓ Factors such as strong leadership, consistent administrative commitment, and thorough planning are essential but not sufficient elements of successful implementation and routinization.
- ✓ Adequate and timely feedback, after the point of initial implementation, regarding fidelity and outcome information are crucial to sustaining buy-in at all levels as well as to identifying real-time barriers and solutions to successful implementation.
- ✓ Attitudes toward evidence-based practices and readiness to undergo the organizational change necessary to incorporate those practices should be assessed during the Exploration and Adoption phase. This assessment should include the participation of all staff, with an ability to identify where there may be resistance (by job classification and by location). Because the implementation of a new/modified practice involves changes throughout the organization; early efforts are needed to involve and obtain buy-in from all sectors. While the willingness of clinical and support staff are essential to implementation, the attitudes of clinical and administrative supervisory staff are key to sustainability. The GAP assessment (focused primarily on organizational resources) in the current project

- demonstrated the power these types of assessments have in terms of helping to identify potential implementation challenges, resource allocation issues etc.
- ✓ Timely and ongoing consultation/supervision in support of transferring new knowledge and skills into practice are just as necessary as high quality training materials and effective dissemination techniques.
 - ✓ It may be particularly beneficial with a complex program/practice, in a large organization with relatively limited resources, to successfully work through the implementation issues in the single site (through the first three phases of adoption, installation and implementation) before introducing and beginning the six-step process throughout the entire organization.
 - ✓ Funding continues to drive the service delivery system. The lack of sufficient reimbursement streams for substance abuse and co-occurring treatment, coupled with the general financial pressure on CMHC organizations such as Bluegrass, creates a substantial “threshold” barrier to the implementation of this evidence-based practice. Without a change in the Medicaid funding environment or securing substantial supplemental funding, it will be extremely difficult to implement, with fidelity, the Integrated Dual Disorders Treatment model endorsed by SAMHSA.

Appendix A: Task Force Mission Statement and Goals

Prior to the implementation of the initiative a mission statement was created by the dual diagnosis task force and communicated throughout the organization. In addition to describing the traditional separation of addiction and psychiatric treatments and rationales for the effort to integrate these services, the document makes the following statement:

“The mission of our agency is to provide a comprehensive continuum of services for individuals with primary substance abuse and primary psychiatric disorders. The treatment continuum encompasses sequential, parallel, and integrated levels of services. Assessment to services is seamless with regard to type of disorder, and initial evaluation integrates both psychiatric and addiction assessment. Assessment determines level of substance abuse and psychiatric severity. Treatment is developed addressing the level of care needed for each disorder. All programs within our continuum of care provide some level of integrated treatment for dually disordered clients. All staff will participate in ongoing training to provide psychiatric and substance abuse assessment and treatment regardless of their primary focus of practice. A comprehensive, integrated continuum of services is essential to delivering quality services to our clients. What this mission statement means for our agency:

- Psychiatric disorders and substance abuse disorders are both primary
- Assessment for both substance abuse and psychiatric disorders will be provided in all of our programs
- We will provide sequential, parallel, and integrated treatment
- Sequential treatment - client is treated for one disorder by one provider then the other by another provider
- Parallel – client is treated by two different providers at the same time
- Integrated – client is treated for both disorders by one provider
- All our programs will provide integrated treatment
- We will provide ongoing training to all of our staff to more effectively address both substance abuse and psychiatric disorder.”